AN EXPLORATION OF THE NEED AMONG NURSES FROM DIVERSE CULTURES FOR A TEACHING PROGRAM ON CULTURAL SENSITIVITY

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DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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ABSTRACT

The objective of this study was to explore the perceived need among nurses from different cultures in a private hospital in Saudi Arabia for a program to teach cultural sensitivity.

The hypotheses for this study were:

- Diverse bio- and demographical/cultural/educational backgrounds of nursing staff have an input on their cultural knowledge and sensitivity of care given in the hospital
- The amount of occurrence reports generated due to cultural differences and clashes indicate the need for a program to teach cultural sensitivity.

A descriptive quantitative study was done, using a self administrative questionnaire on a randomly selected sample 15.8% (n=200) of the population (N=1272) of registered nurses. The data was collected by structured questionnaires with sections requiring the following:

- Biographical information (age, gender, nationality)
- Amount of experience in nursing of patients with diverse cultures
- Nursing education received about caring for patients of diverse cultures
- Cultures of colleagues and patients in the hospital
- Whether incidents occur because of cultural differences
- Amounts of incident reports generated by each respondent per month

The study is descriptive and made use of non-parametric Kruskal-Wallis, Mann-Whitney U and Chi-square computations to determine relationships between the answers of the different respondents to be able to come to a conclusion about the research question.

The study reflects a youthful component of nurses from very diverse cultures working in the hospital, with a large variety of patients of equally diverse cultures. Only 1:5 of the nurses felt that they have enough knowledge about each others' and their patients' cultures.

Recommendations for the implementation of a program for cultural sensitivity are the end result of this study. The ultimate goal for such a program is culturally sensitive nursing where the patients would experience that their culture has been considered in the planning and implementation of their nursing care.

OPSOMMING

Die doelwit van hierdie navorsing was om te bepaal of geregistreerde verpleegkundiges van verskillende kulture by ’n privaat hospitaal in Saudi Arabië die behoefte ervaar en herken vir die aanleer van kulturele sensitiwiteit.

Die hipoteses van die navorsing was soos volg:

- Diverse bio- en demografiese/kulturele/opvoedkundige agtergrond van verpleeglui sal hul kulturele kennis en dus kultuur sensitiewe verpleging in die hospitaal beinvloed.
- Die aantal insidente wat voorkom oor kultuurverskille en botsings is ‘n aanduiding vir die nodigheid van ‘n program om kulturele sensitiwiteit aan te leer.

’n Beskrywende navorsingsontwerp met ‘n kwantitatiewe benadering is in die studie gevolg. ’n Vraelys wat deur die respondente self voltooi moes word, is ingevul deur die ewekansige verkose steekproef van 15.8% (n=200) van die bevolking van geregistreerde verpleegkundiges (N=1272).Die gestruktureerde vraelys het afdelings bevat wat die volgende inligting verlang het:

- biografiese inligting (ouderdom, geslag, nasionaliteit),
- hoeveelheid ondervinding van verpleging van ander kulture,
- verpleegonderrig ontvang in die hantering van pasiënte met diverse kulture,
- kulture van kollegas en pasiënte in die hospitaal,
- of daar insidente voorkom weens kultuur verskille,
- hoeveelheid insidentverslae wat elke deelnemer moet invul per maand.

Die studie is beskrywend van aard en daar is gebruik gemaak van nie-parametriese Kruskal-Wallis, Mann-Whitney U en Chi-kwadraat berekeninge om verhoudinge tussen die antwoorde van die verskillende respondente te bepaal en om tot ‘n gevolgtrekking te kom oor die navorsingsvraag. Die resultate van die navorsing toon dat daar ’n jonger komponent van geregistreerde verpleegkundiges van baie diverse kulture in die hospitaal werk met ‘n groot verskeidenheid van pasiente van ewe diverse kulture. Slegs 1:5 van die verpleegkundiges in die steekproef het gevoel dat hulle oor die nodige kennis beskik m.b.t. mekaar en hul pasiënte se kulture.

Aanbevelings vir die implementering van ’n program vir kulturele sensitiwiteit is die eindresultaat van hierdie navorsing. Die uiteindelike doel van so ‘n program is kultureel sensitiewe. verpleegsorg waar pasiënte ervaar dat hul kultuur aangespreek word in die beplanning en implementering van sulke sorg

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ABBREVIATIONS

SAUDI	A person of Saudi-Arabian nationality
CME	Continuous Medical Education
OVR	Occurrence variance reports
RN	Registered nurse
USA	United States of America

CHAPTER 1:
OVERVIEW OF THESIS

1.1 INTRODUCTION

Technology has brought countries much closer together in this global age as people from different cultures and religions find themselves connected and working together (Leininger, 1995:120). The health sector has not escaped any of these changes. Patients and healthcare providers often find themselves in a multicultural environment. This combination of cultures in the healthcare setup forces one to consider the following questions:

- Do the patients receive optimal care in such a multicultural environment?
- Do the healthcare workers experience support in caring for their diverse patients, and in working in a multicultural team?
- Is there a need for a program to assist them in their functioning and in delivering optimal care to the patient?
- Is there a support system to help with problems that may arise out of such cultural diversity?

The art and science of transcultural nursing owes much to the research of Madeleine Leininger whom was considered by many to be a pioneer in this field. Leininger began her work in the mid 1950's in the United States of America after recognizing an increase in cultural diversity in patients nursed, in service providers, and a trend towards globalisation. This necessitated a new field of nursing care, not confined to the United States of America, but present worldwide (Leininger, 1995:120). The development of the theory and practice of this new field of transcultural nursing was mostly a response to the mass migration of people because of war, disease, poverty and the promise of a. better life in another country (Dyson, 2007:p, ix)

1.2 BACKGROUND

The study was undertaken in a private hospital in the city of Al Khobar in the Eastern province of the Kingdom of Saudi Arabia.

Saudi Arabia occupies four-fifths of the Arabian Peninsula. It is bordered to the northwest by Jordan, to the north by Iraq and Kuwait, to the east by the Gulf of Oman, Qatar, the United Arab Emirates and Oman, and to the South by Yemen (Sfakianakas: 2011).

Figure 1.1: Map of Saudi Arabia and it's regional states (The Saudi network: 2011)

Saudi Arabia has a population of 28,836,000 with a population density of 8.4 per square km (The Saudi Network: 2011).

Saudi Arabia's legal system is based on the Islamic 'Sharia' law and on Decrees promulgated by the Council of Ministers. Sharia is based on the provisions of the Holy Qur'an, the Sunnah (the teachings and deeds of the Prophet Muhammad), the consensus of the 'Ulema' (religious scholars), and legal analogy (Sfakianakas: 2011).

Saudi Arabia has changed from a primitive tribal country to a technology driven country in less than 70 years, with significant changes also in the healthcare sector. The cost in the healthcare sector has increased significantly in the past 20 years and resulted generally in developed countries around the world importing foreign nurses mainly from third world countries to save the cost of training the local population (Sfakianakas: 2011).

Saudi Arabia is such a country that mostly recruits nurses from abroad. Foreign nurses from the Philippines, Indonesia, India, the Gulf States and the Western world work in Saudi Arabia to improve their living standards, as the currency exchange rate work in their favour. Large numbers of people from different nationalities work all over Saudi Arabia.

Importing foreign nurses has helped Saudi Arabia to maintain health care among its citizens at a low cost and kept health care salaries at a bare minimum. Saudis (Saudi Arabian nationals) have not been interested in penetrating this field because of the low salaries offered (Sfakianakas, 2011).

Unemployment amongst the Saudi youth has become a significant problem lately, and programs have been initiated to employ more local people in what was traditionally considered as jobs that only foreigners were recruited for and interested in filling (Sfakianakas, 2011).

Saudisation is a term coined for the preference and policy followed by government to fill posts previously reserved for specially imported foreigners with Saudi nationals. With the new Saudisation standards enforced, only a handful of foreigners would be needed in the country and the rest would phase out eventually by Saudisation in the health sector (Sfakianakas, 2011).

The typical perception of the Saudi people of a nurse until recently was that of a lowly paid employee that belongs to the lower or middle classes. The job description of a nurse was seen to be that of a person that will attend to the patient's needs and follow a physician's orders.

The number of male nurses in Saudi Arabia are more than in other countries when compared with the rest of the world, where nursing is mainly seen as a female career choice. This phenomenon in Saudi Arabia exists due to the Islamic cultural/religious need for the nurse to be of the same gender as his/her patient (Akthar, 2002:np).

However, the majority of nurses worldwide and also in Saudi Arabian hospitals are still recruited from the female gender. The long working hours and night duty associated with nursing do not fit into the Saudi female's strict religious and close-knit family tradition which includes several prayers a day. Such work would interrupt these and other important family rituals. Thus the profession is not appealing to the Saudi population.

There is a state of current flux in the Saudi society today, where a large number of foreigners still remain, and are working side by side with an increasing amount of Saudi's entering the non-traditional sector of nursing. The ability to deliver optimum nursing care in this changing society is questioned, as well as whether respect and understanding is demonstrated by these diverse cultures employed in the health sector.

The researcher is a female, registered nurse of South African decent working in a hospital in Saudi Arabia with 1272 registered nurses of which ninety nine percent are foreigners from all over the world. After reviewing incident reports generated on a monthly basis due to culturally related issues between patients and healthcare workers, the researcher identified a need for a program at the hospital that would teach cross-cultural practices to healthcare

workers. Currently the only education regarding cultural differences is the orientation program that all new employees receive on arrival at the hospital. This orientation consists of a short introduction to national Islamic culture and religion of at most 1-2 hours. It became obvious to the researcher that teaching cross-cultural practices would be highly beneficial to the health worker and the hospital as this might result in a decrease in the number of negative occurrence reports received in the hospital. There was a need to determine if the registered nurses employed by the hospital are aware of the need for such a transcultural program.

1.3 RATIONALE FOR THE RESEARCH

Large portions of the healthcare workers in the Middle East and their patients come from different cultural and demographic backgrounds, each with their own set of belief systems, values and norms. Nurses are part of the healthcare team and they also have specific professional values and norms (apart from the cultural ones) that were internalized during their basic education, training and professional development. One would expect that in a healthcare setting, workers would have shared values, norms and beliefs about health care. In South Africa, for example, the entire healthcare team is educated to respect the patient's privacy and confidentiality. For the nurses this is prescribed by Nursing Act nr 33 of 2005 (South Africa, 2005) that enforces diligence in safeguarding human dignity and protects the public from what is seen as unethical behaviour such as not maintaining a patients' confidentiality.

The patient also has the right to know about their rights to privacy and confidentiality. Outsiders are not allowed to view the health records of the patient; such medical records are highly classified.

In Arab countries like Saudi Arabia, the family has the right to decide about the amount of knowledge the patient (their relative) should receive about the disease. The father or the eldest son will make these decisions. They will also decide about the type of health care that should be delivered. Therefore, the values installed in the healthcare workers in their own country about confidentiality and privacy of the patient and choices about the patient's treatment clashes with the Arabic culture. In this culture the patriarchs of the family need to know medical facts about the patient to make decisions. To illustrate this point, there was an incident where the husband brought his wife in for delivery. Due to an emergency in the hospital there was no female physician available at the time to attend to her. The husband refused any medical assistance from a male physician to assist his wife in any way related to

the labor. She was already far advanced in the second stage of labor, but the husband removed her to another hospital to be attended to by a female physician there. The wife had no say in this matter and followed her husband's guidance.

Transcultural nursing is theory and practice which focus on comparing the needs and nursing care of people with similar and conflicting beliefs, values, and cultures. Such a focus will ensure the provision of culturally congruent, meaningful, and beneficial health care (Leininger, 1995:20). Transcultural nursing is an essential area of study for nurses to enable them to obtain knowledge and skills necessary to function in a society that includes groups of people from different cultures (Dyson, 2007:11).

People from different backgrounds will soon become distrustful, discontented and unhappy with their care if nurses show little knowledge or skills in meeting their particular healthcare needs. Nurses should gain an understanding of the beliefs, the values, lifestyle and religious practices of the particular cultures in the society that they work in. This will enable them to become knowledgeable and skilled in dealing with local and foreign patients (Dyson, 2007:12).

The goal of teaching a cross-cultural sensitivity program is to prepare nurses who are knowledgeable, sensitive and render medico-legally safe care in a multicultural environment (Dyson, 2007:12).

Understanding and appreciating cultural diversity is essential to enable the different individuals and cultural groups to participate and develop autonomously within the society, community and healthcare setting (Nyatanga, 2001:56; Pellat, 2007:366; Gunaratman, 2007:470-471).

The needs of diverse and multicultural societies especially where their health is concerned, must be met. Generally there is a lack of recognition of different cultures and their health needs, specifically in a private hospital in the Muslim culture and geography. This instigates many problems for a mostly internationally trained nursing workforce when providing care for local and international patients. These problems manifest in occurrence reports and cultural clashes.

The need to know whether these nurses recognise, acknowledge and accommodate the differences between themselves and their colleagues and themselves and the patients, necessitated this study. This study proposed to ask whether nurses are aware that cultural differences exist and give cause to occurrence reports, and to determine their thoughts on

the need to know more about other cultures to understand each other and their patients better

The results of this study will help determine the need for a program in teaching these nurses culturally sensitive care in their environment. It will also help them to recognise and verbalise symptoms like stress and anxiety amongst themselves and amongst patients due to cultural differences and clashes. It will help them to recognise that cultural clashes could be responsible for generating a large number of occurrence reports. Lastly it will enable them to become efficient advocates for their patients in obtaining culturally acceptable and safe care.

1.4 RESEARCH PURPOSE

The purpose of the study is to determine the perceived need among nurses from diverse cultures for a teaching program on cultural sensitivity.

1.5 RESEARCH QUESTION

The research question “What is the perceived need among nurses from diverse cultures regarding the need for a program of teaching on cultural sensitivity?” guided this study.

1.6 RESEARCH AIM AND OBJECTIVES

The **aim of the study** was to determine whether there is a perceived need among nurses from diverse cultures for a teaching program on cultural sensitivity.

The **objectives for the study** were to:

- Identify the different cultures of the nurses and that work in the hospital, and their patients.
- Determine the self- reported cultural knowledge of nurses about their patients.
- Determine whether nurses received previous training/orientation and/or have experience in dealing with cultural diversity.
- Determine the effect of the demographic variables on cultural competence as displayed by frequency of occurrence variance reports filled in and the amount of stress experienced as was reported when working with other cultures.

1.7 RESEARCH DESIGN

A quantitative descriptive study was done in the private hospital in Saudi Arabia. This was done to determine the perceived need for a program for teaching cross-cultural practices for nurses in the health care setting.

1.8 RESEARCH INSTRUMENTATION

A Likert scale self-administered questionnaire was compiled. This questionnaire consists of a biographical section; a section about experiences in diverse cultural settings; a section about current cultural knowledge; and a section about occurrence reports. A Likert scale with 4 points asked for responses in the section where respondents had to comment on their cultural knowledge where 1 = strongly agree, 2 = agree, 3 = neutral and 4 = disagree. A statistician at Stellenbosch University was consulted about the contents and the feasibility of the instrument.

1.9 RESEARCH POPULATION

The population for the purpose of this study was all the registered nurses, working in the private hospital in Al Khobar in Saudi Arabia at the time.

The numbers of registered nurses employed at the private hospital were (N= 1272) at the time of the study. The researcher took 18% (n=227) from the (N=1272) registered nurse of whom the identification numbers were entered into the computer and then were randomly selected by the computer. The people whose names were chosen by the computer, were asked to complete the questionnaire.

1.10 DATA COLLECTION

The fieldworkers distributed the questionnaires to selected respondents. The questionnaires were collected between the third day and the seventh day after distribution and after reminders were e-mailed to the entire group of selected respondents.

1.11 DATA ANALYSIS

A statistician subjected the data collected from all the respondents to statistical computation analysis with Statistica (version10) and it is displayed by using Microsoft Excel software.

The data is displayed in suitable graphs and tables to enable interpretation. Inferential statistics such as percentages, the Chi square test, the Kruskal-Wallis test, Mann Whitney U test, were used to explain the data and the relationships.

1.12 ETHICAL CONSIDERATIONS

Ethical approval to conduct the study was obtained from Stellenbosch University's Ethical Committee for Human Research. Written approval to do the study was also obtained from the management of the hospital where the study was conducted. Participants were asked to give written permission to take part in the study. Anonymity and confidentiality were

maintained by asking the participants not to identify themselves on the questionnaire. They were reassured that they could withdraw from the study at anytime without any obligations.

1.13 VALIDITY AND RELIABILITY

Validity was addressed by ensuring that the questions were relevant to the topic studied. A panel of nursing specialists at proposal discussions at Stellenbosch Nursing Division revised the questionnaire, as well as specialists in management of the hospital where the study was done. Reliability was assured by applying the questionnaire in the same way to each respondent.

1.14 THEORETICAL FRAMEWORK

The model of Campinha-Bacote and Munoz (2001:48-52) was used to provide structure to this study. This model has five components, to continuously strive towards in becoming culturally competent in the delivery of health care. Development of cultural competence is however ongoing throughout a nurse's career and can never be fully mastered (Catalano, 2003:393-411).

The answers of the respondents helped to determine where they are in this process of obtaining cultural competence, as well as what their perceived need is to learn more about their patients' and each other's culture.

1.14.1 Cultural awareness

This is an insight into your own as well as another's culture, beliefs and values. An examination of the respondents' own demographical and cultural background, basic training and previous exposure to other cultures help to determine what effect this input has on their own cultural awareness. An insight in your own culture will facilitate greater awareness of other people's culture (Flowers, 2004:50).

1.14.2 Cultural knowledge

This is the process of obtaining information about different cultures and ethnic groups. Education in transcultural nursing and availability of educational resources are necessary to obtain cultural knowledge so as to deliver culturally sensitive care (Flowers, 2004:50). The basic education in nursing and training the respondents had in other hospitals and in their current hospital on cultural diversity were examined in this study to determine the impact this had on the current knowledge of the nurses about the diverse cultures they work with.

1.14.3 Cultural skills

This is the ability of the nurse to collect relevant cultural data about the client's presenting problem and physical assessment and to act with cultural sensitivity on this information (Flowers, 2004:50). Respondents' insight into reasons for the prevalence of occurrence reports (due to cultural clashes) were examined and the information obtained reflected on their level of cultural skills.

1.14.4 Cultural encounters

These are the processes where the nurse directly engages in cross-cultural interactions with culturally diverse patients (Flowers, 2004:50). The degree to which respondents function on this level was determined by self-reporting of the different cultures the respondents work with on a daily basis (patients and colleagues) as well as the years of experience they have had working with different cultures, and the amount of confidence they have with dealing with them. Self-reporting on the need to de-brief and the effect of previous orientation programs to address stress induced by working with different cultures help to determine whether the respondents are functional on this level.

1.14.5 Cultural desire

This is the last component of the model where the nurses increasingly become culturally aware and actively seek cultural encounters. The purpose of this study was to determine whether the participants have a desire for more information on culturally diverse issues, to be able to render more culturally sensitive care to their patients (Flowers, 2004: 50).

The model of Campinha-Bacote and Munoz (2001:48-52) will be discussed in more detail in chapter 2.

1.15 OPERATIONAL DEFINITIONS

Culture: Learned, shared, and transmitted knowledge of values, believes norms and lifeways of particular group that guides an individual or groups in their thinking, decisions, and actions in patterned ways (Leininger, 1995:60).

Culture care diversity: The variation of meanings, patterns, values, lifeways, or symbols of care that are existing amongst humans from different cultures for their well-being, through assisting, supporting, facilitating, or enabling (George: 2002:589).

Cultural competence: Having an awareness of your own existence and environment without letting it have an undue influence on those from other backgrounds; demonstrating

knowledge and understanding of the patient's culture; accepting and respecting cultural differences; adapting care that is congruent with the patients' culture (Flowers, 2004:49).

Occurrence variance report: This document (OVR: 015-016) is formulated and revised for the use in this specific private hospital to facilitate the policies and procedures for this establishment. This form should be completed by the person that witnesses a negative occurrence. This completed OVR form is then sent to management and the performance improvement department to investigate the problem and to find a suitable solution (Specialist hospital: 2010).

Registered nurses: Nurses who have double registration in the country of their origin as well as with the Nurse Council (Health council MOH – Ministry of Health) in Saudi Arabia and who works within a specific Scope of Practice as independent practitioners, but also together in the health care team towards the improved health of a patient.

Sharia' law: Sharia, Islamic law, influences the legal code in Muslim countries. A religious movement that allows Sharia principles to govern the laws and customs that relate to personal status. It is also a set of regulations that pertain to marriage, divorce, inheritance, and custody. It is even expanding in the west (Sfakianakas: 2011).

Transcutrural or cross-cultural nursing: Area of study and practice focused on comparing cultural (caring) values, beliefs, and practices of individuals or groups, of similar or different cultures to provide cultural-specific and universal nursing care practices in promoting health or well-being or to help people to face unfavorable human conditions, illness, or death in culturally meaningful ways. (Leininger, 1995:58).

Ulema: A Muslim scholar trained in Islam and Islamic law (Sfakianakas: 2011).

1.16 CONCLUSION

This chapter introduced the area of interest of the thesis, and the geographical and political setting of the hospital being studied in Saudi Arabia. The purpose of the study design and the theoretical frame work of the study were explained. In the following chapter the literature review of the study is discussed.

CHAPTER 2:
LITERATURE STUDY

2.1 INTRODUCTION

This chapter covers the literature found during a search of aspects of nursing across cultures. The need for culturally sensitive nursing has been identified internationally by important authors such as Madeline Leininger. The information generated by her has helped to identify and define the research problem, prepare the research design, and develop the questionnaire and initiate this study.

2.2 DEFINITIONS OF CULTURALLY DIVERSE CARE

Madeleine Leininger defines culturally diverse care through the concept of "transcultural nursing" as a formal area of study and practice. Transcultural nursing is focused on comparing differences and similarities of the beliefs, values and patterns of life of the different cultures to be able to provide culturally congruent, meaningful, and beneficial healthcare (Leininger & Mc Farland, 2002: 62). Madeleine Leininger is considered as the pioneer in the field. She began her work in the 1950's in the United States of America on recognising marked increase in cultural diversity, and a trend towards globalisation. This she argued, necessitates a new field of nursing care, namely transcultural nursing, not confined to the USA, but worldwide (Leininger, 1995) Since then the theory and practice of transcultural nursing has developed in many countries (Dyson, 2007). Leininger emphasizes the importance of culture in explaining an individual's health and caring behaviour (1995:89). "Her Culture Care Theory" brought great insight to nurses and enabled them to provide culturally sensitive care (George, 2002: 489).

Cultural competence is having an awareness of your own existence and environment without letting it have negative influence on those from other backgrounds: demon- strating knowledge and understanding of the patient's culture; accepting and respecting cultural differences; adapting care that is congruent with the patient's culture (Flowers, 2004: 49).

2.3 THE NEED FOR CULTURALLY DIVERSE CARE

Leininger discovered that patients from diverse cultural backgrounds valued culturally sensitive care more than their nurses did (George, 2002:499). In a study done in England by Vydelingum (2006:23) it was found that white nurses had a tendency to treat all minority ethnic patients the same, and provided evidence of ethnocentrism, victim-blaming

approaches and poor cultural competence, indicating the need for further training and development (Somerville, 2007:580).

A small qualitative study was done in Norway (Ekblad, Marttila & Emilsson, 2000:624) examining cultural challenges in end-of-life care. Nursing staff felt that merely possessing knowledge about different cultures was inadequate, as culture should be highlighted in the individual context. 'Cultural clashes' could occur when differences stemming from the patient's cultural identity caused them to behave differently to the staff from the host culture. Communication across a language barrier was also a source of frustration (Somerville, 2007:580). Nyatanga (2007:34) in Africa warns of cultural colonialism, which leads to stereotyping of cultures and groups. This stereotyping leads to inappropriate and insensitive care of patients. Flowers (2004:49) defines stereotyping as oversimplified conceptions, opinions or beliefs about some aspect of an individual or groups of people's culture. She warned against stereotyping that would result in inadequate care delivered and pleads for cultural awareness which would prevent stress experienced by patients in North America where her study on culturally competent care was done.

Nyatanga (2001:56) said that healthcare workers and patients need to develop ways of understanding each other and understand the framework each other's decisions were made upon. This will assist them to treat each other as equals and not to view one culture as better or worse that the other. Somerville (2007:580) reiterates by stating that there is an urgent need for awareness and understanding amongst health care workers to cross cultural barriers so as to enhance communication skills, to properly interpret patients' need for care and to be their patients' advocates (Somerville, 2007:580). Black (2008:12) states that consequences of understanding cultural diversity will create opportunities to understand and learn different ways of viewing our worlds. It will also help to appreciate commonalities across cultures and help us to develop relationships and interact with each other in a non-judgmental way.

George (2002:499) and Andrew and Boyle cited in Pellat (2007:368) said that a culture is dynamic (ever changing), inter-related and has input from religious, social, political and economical structures in it's specific society. Education and technology also have an influence on cultural values, language and a culture's ethno-historical features (George, 2002:499). The sharing of cultural beliefs and patterns bind people together as a group with one identity (often an unconscious process). Culture, according to Andrews and Boyle, is a

holistic adaptation to specific activities related to the environment and necessary technical factors (Pellat, 2007:368).

Holland and Hogg (Pellat, 2007:366) state that culture is an "…inherited or learned set of guidelines that are used to enable the individual to live in a social group or society…". Andrews and Boyle (Pellat, 2007:368) agree that culture is learned from birth through language and socialization and that all members of the same culture groups share the culture. Each society has its own set of values, norms, beliefs, practices and taboos, especially concerning health care which provides the framework for individuals to live in, and the way they interact and treat each other (Pellat, 2007:366).

2.4 MODEL FOR UNDERSTANDING LEVELS OF CULTURAL CARE

Campinha-Bacote and Munoz (2001:48-52) created a model with five components to develop cultural competence in the delivery of health care. These components are: cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire.

2.4.1 Cultural awareness

This status is more than just learning about another person's culture. It is a thorough insight into an individual's cultural healthcare, beliefs and values. This means that the nurse must first do a self examination and exploration of her own cultural and professional background. Catalano (2003:393-411) says that nurses must first under- stand their own cultural backgrounds and explore the origin of their own prejudices, before they can attempt to study and help others. Black (2008:10) also agrees that nurses should be aware of their own cultural heritage to respect and appreciate the values, beliefs and practices of others. Thus, the nurse must have a combined self-awareness as well as insight about other cultures to be culturally competent.

2.4.2 Cultural knowledge

This is the process of obtaining information about different cultures and ethnic groups. Knowledge bases can be expanded through consulting journal articles, internet resources, and attending seminars, workshop presentations, and university courses. (Flowers, 2004:50).

However, Somerville (2007:580) adds that merely possessing knowledge about a culture does not imply that the health care worker has the ability to provide for the needs of patients within their cultural context and across cultural boundaries. Education and availability of resources are also necessary to deliver culturally sensitive and knowledgeable care.

2.4.3 Cultural skills

This includes the ability of the nurse to collect relevant cultural data about the client's problems and ailments. The purpose is for the student to understand that even if one person resembles another, they are not necessarily from the same cultural heritage and can therefore may have quite different cultural beliefs and values (Flowers, 2004:50). Stereotyping also causes one to ignore the differences between people of a culture, e.g. the tendency to see all Christians or all Muslims as homogenous groups, instead of individuals with possibly vastly different belief systems, although being part of one of these groups.

2.4.4 Cultural encounters

This is the process where the nurse directly engages in cross-cultural interactions with culturally diverse patients. This helps nurses to develop cultural competence throughout their careers in an ongoing and evolving process (Flowers, 2004:50).

2.4.5 Cultural desire

This is the last component of the model where the nurses becomes culturally aware and actively seek cultural encounters. The nurse has a willingness to be open to others, to accept and respect cultural differences, and wants to learn from them (Flowers, 2004:50).

Nurses who are culturally competent will demonstrate features such as tolerance in ambiguous situations, flexibility and respect for cultural differences, empathy, communicative awareness, and knowledge on how to deal with culturally problematic issues (Black, 2008:18).

Holland and Hogg (Pellatt, 2007:366) state that the healthcare worker has to become part of a new culture/group in the hospital. Nurses should focus on providing culturally sensitive care and should avoid assimilating themselves into any specific and exclusive cultural grouping in the hospital setting.

2.5 THE ULTIMATE GOAL OF CULTURALLY SENSITIVE CARE

The ultimate goal of implementation of such a culturally sensitising program is for nurses to provide a voice to their patients within a diverse multicultural healthcare setting. Giving the patient a voice and treating the sick person with the dignity and the respect that any human deserves, will be beneficial to the patient as an individual and enable such a person to access healthcare service with confidence. In New Zealand healthcare workers encourage "cultural safety", which means giving everyone a voice within the medical culture. They are

thus able to negotiate for improved health, as well as optimal health care. (Flowers, 2004:547).

Increased consumer demand and the ability of lay persons to pay for costly court cases emphasise the urgent need for culturally competent care in an increasingly diverse multi-cultural society. Furthermore, nurses need to realize that health care is becoming more technical and it is not necessarily understood by large portions of society. Nurses need to recognise and acknowledge this and increasingly act as advocates for their patients of diverse backgrounds and cultures (Flowers, 2004:548).

The tragedy of events like the September 11th attacks highlights the problem of ignoring the need for the recognition of the different cultural societies (Flowers, 2004:49). In hospitals where the 'East meets the West' regarding different staff and/or patient cultural mixes, it is thus very important to address the need for feelings of safety of colleagues and patients who represent the internal clients (colleagues) and external clients (patients) of the healthcare worker. Feelings of safety generated will ultimately translate into culturally safe and sensitive care.

2.6 SUMMARY OF LITERATURE SEARCH

The literature review established that culturally sensitive and competent care is essential for nursing in the 21st century. This is because of globalisation and cultural encounters with societies and institutions that have previously been considered to be worlds apart. Saudi Arabia has traditionally been an importer of foreign nurses, especially from the 'East' and the 'Far-East', but also from the 'West'. Thus the nation has always been exposed to other cultures. However, the recent acceleration of the Saudisation process has resulted in Arab nurses representing a larger section of the health team. Consequently, many Saudi nurses have been exposed to healthcare workers originating from other countries, (Jordan, Egypt, Philippines, India, America, South Africa, England and Lebanon) and had to learn to work with patients other than their traditional Muslim countrymen.

These factors were the triggers for investigations to determine whether the nursing care delivered by all the cultures present in the healthcare team is culturally sensitive and to determine whether these team members are culturally competent. It was also necessary to determine this to ensure that the patients from multicultural backgrounds get the care they expect and pay for from a private hospital, in a foreign country.

Campinha-Bacote's and Munoz's model (2001:48-52) with its five components of culturally competent care will be used in this study to determine where the hospital is on its way to cultural competence and if the culturally diverse staff have the knowledge to successfully deal with cultural clashes and issues. Such a situation will also be reflected in the decreased amount of OVR reports handed in to management.

2.7 CONCLUSION

Definitions and explanations of culturally sensitive and competent care were examined in this chapter, and Campinha-Bacote's and Munoz's model (2001:48-52) with its five components was explained. The ultimate goal and rationale for cultural sensitive care is for the nurse to give the patient a voice and be an advocate for such an individual's total care, with the patient's culture as one of the biggest determinations of how the patient should be cared for.

In the following chapter the research methodology is explained in detail.

CHAPTER 3:
RESEARCH METHODOLOGY

3.1 INTRODUCTION

In this chapter the research design is presented, reliability and validity of the study is discussed in detail and the method of data collection as well as the questionnaire that was used in this study, is explained.

3.2 RESEARCH QUESTION

The research question "What is the perceived need among nurses from diverse cultures regarding the need for a program of teaching on cultural sensitivity?" guided this study.

3.3 RESEARCH AIM

The aim of the study was to determine whether there is a perceived need among nurses from diverse cultures for a teaching program on cultural sensitivity.

3.4 RESEARCH OBJECTIVES

Objectives are clear, concise, concrete, measurable statements towards which goals are directed (Brink, Van Der Walt, & Van Rensburg, 2006:79). The objectives for the study were to evaluate the background and current situation of the nurses to:

- Identify the different cultures of the nurses that work in the hospital and the cultures of their patients
- Determine the self- reported cultural knowledge of nurses about their patients.
- Determine whether nurses received previous training/orientation and/or have experience in dealing with cultural diversity.
- Determine the effect of the bio- and demographical variables on cultural competence as displayed by frequency of occurrence variance reports filled in and amount of stress experienced as reported when working with other cultures

3.5 RESEARCH DESIGN

A research design is a blueprint for conducting a study. It maximizes control over factors that could interfere with the validity of the findings. Furthermore, it guides the planning and implementation of a study in a way that is most likely to achieve the intended goal (Burns & Grove, 2007:553).

The design of this study is quantitative and descriptive in nature.

Quantitative research is a formal, objective, and a systematic process used to describe variables, test relationships between them, and examine cause-and- effect interactions among these variables (Burns and Grove, 2007: 551, Brink et al, 2006:102). A quantitative design can be non-experimental where there is no manipulation of the independent variable, but the phenomena are observed as they occur. This type of design is very useful in generating knowledge in a variety of situations in which it is difficult to use an experimental approach (Brink et al, 2006:102).

A descriptive design is used to identify a phenomenon of interest, identify variables within the phenomenon, develop conceptual and operational definitions of variables, and describes variables (Burns & Grove, 2007:537). This design is used in studies where more information is needed in a specific area of concern through the provision of a picture of the phenomenon in its natural environment (Brink et al, 2006: 102).

A quantitative descriptive study design was used to measure the perceived need among nurses from diverse cultures for a program teaching cultural sensitivity for nurses in their healthcare setting. A quantitative design was seen as suitable for this study as this design helps identify the phenomenon of interest, which is 'cultural sensitivity' and competence' amongst nursing staff in their natural setting of a multicultural private hospital in a traditionally Muslim country.

3.6 POPULATION

The population of interest was all the (N= 1272) registered nurses employed in the private hospital in Saud Arabia at that period of time. The registered nurses were from a vast range of specialties, nationalities and of both genders. The nationalities included South Africans, Americans, Indians, Jordanians, Egyptians, Saudi/Palestinians, Lebanese, Filipino's, English, and Malaysians.

3.7 SAMPLING

Sampling is the process of selecting a group of people, events, behaviours, or other elements that are representative of the population being studied (Burns & Grove, 2007: 554). Probability sampling was used in this study which ensures that all elements in the population had an equal chance of being included in the sample. This allows the reduction of sampling error and bias, so that the researcher will draw accurate conclusions through inferential statistics (Brink et al, 2006:126). Sampling error indicates that the sample does not provide a precise picture of the population. This is caused by variations that may occur by chance when a sample is chosen to represent the population (Brink et al, 2006:125). Bias can occur

when samples are not carefully selected, for example when the personal views of the researcher influences the data and where the researcher is guided by preference when selecting the sample (Brink et al, 2006:126).

3.7.1 Size of sample

Sample sizes are the number of subjects, events, behaviors, or situations that are examined in a study (Burns & Grove, 2007: 554).

A sample size of 18% was seen to be representative of the population of (N=1272) registered nurses working at the hospital. This meant that 227 participants were needed.

According to Giovanetti (1981) quoted in Brink et al (2006:135), 'equal precision' is found when the population is 2000 and the sample size is 10% (200) rather than in samples larger than 10%. Brink et al (2006:136) also quote De Vos (2002) who says that an over-large sample may be overly sensitive and can increase costs and so become unethical.

3.7.2 Sampling method

Simple random sampling was done in this study. Random sampling is a technique in which every member (element) of the population has a higher chance than zero to be selected for the sample. This aspect increases the sample's representation of the target population and the ability to make generalizations from the research findings (Burns & Grove, 2007:554). There are various techniques of simple random sampling, and a computer-generated selection of random numbers are a commonly used one (Brink et al, 2006:127).

In order to give all the respondents an equal chance to take part, the identification number of each registered nurse were entered into the computer, the computer randomly selected the numbers matching them to the individual registered nurses name working in the hospital at that period. The randomly selected names were printed on a list and submitted to the fieldworkers. The benefit of using this system was the exclusion of bias as everybody had a fair chance to be chosen to participate. The only factor negatively affecting random selection would have been the unwillingness of selected participants to take part in the study.

When this would happen the plan was to select another name from the computer. In this study everybody that was selected chose to participate. Some of the respondents were hesitant to complete the questionnaire, but after a detailed explanation of the purpose of the study they complied.

3.7.3 Criteria for inclusion of the respondents

Representativeness is necessary to ensure that the sample is as similar to the population as possible (Brink et al., 2006:125). As the hospital employs mainly **registered** nurses, the criteria for inclusion of the respondent was that he/she must have been working as a registered nurse in the specific private hospital where the study was conducted at the time. No limit was put onto the amount of time the person had to work in the hospital for her/him to partake.

Another criterium was that the person had to be willing to sign a consent form to agree to participate freely in the survey with the understanding that he/she can withdraw anytime and had no obligations at all towards to the study.

3.8 RESEARCH INSTRUMENTATION

A research instrument is a component of measurement that involves the application of specific rules to develop an instrument to measure a phenomenon (Burns & Grove 2009:704).

This study made use of the survey as a data collection approach. With this technique questionnaires are used to gather data about an identified population (Burns & Grove 2009:695).

A questionnaire is a self-report technique to find out what people believe, think or know. This includes their thoughts, perceptions, attitudes, beliefs, feelings, motives, plans, experiences, knowledge levels and memories (Brink et al, 2006:146).

3.8.1 Research instrument

A self-administered questionnaire was developed by the researcher based on the literature research and the experience of the situation at hand. The questionnaire included mostly questions from which the best option must be chosen and a Likert scale with 4 points where 1= strongly agree, 2= agree, 3= neutral and 4= disagree, requiring responses were developed.

Section A: comprised of biographical information that requested the respondents'

- age, gender and nationality

Section B: comprised of questions about their experience in diverse cultural settings.

- Years of experience
- Orientation and training received in cultural diversity

- Cultures of patients and colleagues

Section C: comprised of questions about current cultural knowledge and support measured per Likert scale with 4 points where 1= strongly agree, 2= agree, 3= neutral and 4= disagree. Their opinions were measured about:

- Need to know patient's culture
- Amount of current knowledge about culture, cultural needs and taboos
- Help of current orientation program to deal with stress induced by cultural diversity
- Support of peer/person to debrief with

Section D: comprised of questions about regularity of occurrence reports that had to be completed by the respondents

Research specialists at the nursing department of Stellenbosch University as well as the hospital management gave permission to use the questionnaire after it was screened by them and found satisfactory. A statistician at Stellenbosch University was also consulted about the content and feasibility of the instrument.

3.8.2 Advantages and disadvantages of a questionnaire for this study

A well-designed questionnaire is easy to use for literate respondents, a quick way of obtaining data from a large group of people, and people feel a greater sense of anonymity and thus are more likely to provide honest answers. The format is also standard for all subjects (Brink et al, 2006:147).

The questionnaire was relatively easy to fill in, and the data obtained easy to interpret as it was mostly nominal and ordinal and some interval data.

Disadvantages of this type of survey are low response rates, failure to answer some items, no opportunity to clarify items (Brink et al, 2006:147). In this study some 27 respondents misunderstood a portion of the questions. This resulted in incomplete questionnaires that had to be discarded, and a smaller sample size of 15.8% (200) instead of the anticipated 18% (227).

3.9 RELIABILITY AND VALIDITY

Burns and Grove (2007:365) identify reliability and validity as," the determination of how well the instrument reflects the abstract concept that is being measured on a continuum " and "… that it is not an all-or-nothing phenomenon…"

Reliability refers to the degree to which the instrument can yield consistent results (Brink et al. 2006:164). It should also be sensitive enough to detect change, to ensure that valid data is collected (Brink et al, 2006:164). For this study it means that the instrument would be able to specifically measure differences in opinion between respondents with different attributes, regarding nationalities, gender and aspects like experience in cultural diversity nursing.

Validity in an instrument means that it measures what it is supposed to measure (Brink et al, 2006:159). In this study it means that the instrument would measure the opinions of the registered nurses at the hospital about how effectively they address the needs of their culturally diverse patients and whether they have a need for more education to meet these needs.

After the development of the questionnaire by the researcher, it was presented to the quality performance committee at the hospital for screening and determination of relevancy, reliability and the validity of the questions. This committee consisted of the divisional director, three registered nurses specializing in quality improvement and a physician.

A quality performance specialist (a registered nurse with experience in designing survey questionnaires) and the chief executive officer of the hospital also reviewed the questionnaire.

At a proposal presentation at Stellenbosch University the questionnaire was refined and the final revision and approval was done by the Ethics Committee and a statistician of the university, further validating the instrument.

Two fieldworkers from the nursing education department helped distribute the questionnaires. The names of the randomly computer-selected respondents were provided to the fieldworkers on a printed list and in this way favoritism by researcher/fieldworkers was eliminated as they could not choose the respondents.

Since the questionnaire was self-administered and allowed nurses to complete the questionnaire in the absence of the researcher, bias was reduced as the researcher never had contact with the respondents.

3.9.1 Face Validity for the questionnaire

Face validity is verification that the instrument measures the desired content (Burns & Grove, 2007:540) and according to Brink (2006:160) it is the most obvious kind of instrument validity.

Face validity was obtained by ensuring that the questions cover what the researcher said was to be studied in the proposal, namely the effect that bio- and demographical detail of the respondents have on their cultural knowledge and experience in working with other cultures.

3.9.2 Criterion validity

Criterion validity is the extent to which the demonstrated are related to concrete criteria in the "real world" (Burns & Grove, 2007:365). It focuses on establishing a relationship between scores on the instrument and other external criteria (Brink et al., 2006:160).

Criteria have been set by authors such as Madeleine Leininger for the delivery of culturally competent care in her cultural care model (George, 2002: 489). Authors like Flowers (2004:49) also commented on the need to understand an ever-increasing diverse population.

Criterion validity are shown with the study aligning with the literature found on the topic of culturally sensitive care necessary, and when the same conclusions are reached with the study as these authors.

3.9.3 Construct validity

Construct validity determines whether the instrument measures the theoretical construct it purports to measure (Burns & Grove, 2009:535; Brink et al, 2006:162). Construct validity is useful for measures of feelings, such as anxiety and satisfaction and is more complex and measured over time by several people (Brink et al., 2006:162).

Construct validity will be proven by inspecting the independent variables of age, gender, nationality and years of experience to determine whether it has an influence on the cultural sensitivity and knowledge of the nurse, and whether it impacts on the skills he/she uses to render compassionate and culturally competent care. Measuring the self-reporting of anxiety and stress levels and confidence in dealing with other cultures will contribute to determine construct validity.

The sample's awareness of insensitive cultural behaviour and its influence on the generation of occurrence reports is also examined and further contributes to concurrent validity of the study as it builds on the notion that more culturally adept individuals generate fewer occurrence reports. Campinha-Bacote and Munoz's model (2001:48-52) of the different levels of cultural competence (Flowers, 2004:50) is an important construction for this study and will give directions to the interpretation of the data and provision of concurrent validity of the study.

3.10 DATA COLLECTION

Data collection is the precise, systematic gathering of information relevant to the research purpose or the specific objective, questions, or hypotheses of a study (Burns & Grove, 2007: 536).

3.10.1 Administration of the Questionnaire

An accompanying letter of introduction to the questionnaire explained the purpose and importance of the study to encourage the sample chosen to participate. It was explained that no names or form of identification were required on the form so as to ensure anonymity, privacy and confidentiality to the respondents as per the ethical principle of justice (Brink et al., 2006:33). The respondents also had a choice to withdraw anytime if they wished not to continue with the study as per the ethical principle of respect for persons (Brink et al, 2006:32).

Two registered nurses from the education department were the appointed fieldworkers and they issued the questionnaire to the selected respondents. They explained the questions where necessary.

Selected respondents who were unwilling to partake were contacted by the researcher and the fieldworker and the reason for the study was explained, as well as how to complete the questionnaire. All respondents given this explanation decided to partake.

The document included instructions for the delivery of the questionnaire "please complete in full and place in selected marked survey box". Survey boxes were placed on marked areas where it was easily accessible to the respondents.

The data collection forms were returned on the third day after distribution. Initially the return rate was poor as predicted with questionnaires (Brink et al, 2006:147), but reminders were sent via e-mail to all selected respondents to attempt to overcome this problem. The final collection was on the seventh day after distribution.

3.11 DATA ANALYSIS AND INTERPRETATION

Data analysis is the technique used to reduce, organize and give meaning to data that is collected during a study (Burns & Grove, 2007:536).

Interpretation is the process where the researcher examines the results from data analysis, form conclusions, consider the implications for nursing, explore significance of the findings, generalize the findings and suggest further studies (Burns & Grove, 2007:543).

All the questionnaires were collected by the fieldworkers and handed over to the researcher. They were then counted manually and separated into complete and incomplete questionnaires.

The response rate was 100% but only 88% or 200 questionnaires came back fully completed. This reduced the sample size to 15.8% (n=200).

Statistica 10 software was used for the statistical computation of the data and analysis was done with the aid of a statistician. The responses for each question are displayed in a histogram or graph under their categories in chapter 4. The relationship between the variables were determined and calculated to explain the phenomenon and conclusions by means of Chi-square, Mann-Whitney U and Kruskal-Wallis non-parametrical inferential testing.

3.11.1 Inferential statistics and P-value

Inferential statistics permit the researcher to infer that particular characteristics of a sample reflects the status of the larger population, and help to determine whether there are a true difference found between groups, or whether the difference are only by chance. The P-value is the probability that the outcome is due to chance. If the P-value is <0.05 it is the significance or lack of significance of the data to prove that the difference between the groups are due to chance (Brink et al., 2006:171).

3.11.2 Chi-square test

This statistical test determines differences in proportions and helps to describe statistics and to infer a relationship between two variables and comment on the strength of this relationship (Polit & Beck, 2008:749).

3.11.3 Mann-Whitney U test

This statistical test determines differences between two groups, based on a rank score (Polit & Beck, 2008:757).

3.11.4 Kruskal-Wallis test

This statistical test determines differences between three or more groups, based on rank order (Polit & Beck, 2008:757).

3.11.5 Mean

The mean is a measure of central tendency which measures the mathematical average of all the scores in a distribution (Brink et al., 2006:177).

3.44.6 Mode

The mode is the value or score that occurs most frequently in a distribution (Brink et al, 2006:177).

3.11.7 Median

The median is the midpoint score or value in a group of data ranked from lowest to highest (Brink et al., 2006:177).

3.12 ETHICAL CONSIDERATION

Ethical approval was obtained from the Stellenbosch University's Committee for Human Research (Proposal N10/08/273); prior to commencement of the study. This ethical approval (Annexure A) included the ethical committee's review of all factors that might infringe on the right of respondents.

Written approval to conduct the study was also obtained from the hospital management (Annexure B).

The respondents were informed through the cover letter that the hospital and the ethics committee of the university approved the study. The questionnaires included an instruction section with the aim of the study (Annexure C).

A consent form was attached to the document which the respondents had to sign. This had to be returned separately from the questionnaire to ensure that the name on the consent form would not be associated with the completed questionnaire, ensuring anonymity to the respondents.

The data collection form was distributed to the respondents individually and with an enclosed envelope so that they could deliver it into a box after completion, ensuring further anonymity.

After completion of the research, the completed questionnaires were filed away in the hospital archives where it will be kept for a period of two years with the permission of the Divisional Director. No entrance to unauthorized persons is allowed.

3.13 DISTRIBUTION OF RESULTS

Distribution of the results include submission of the research report to the medical director of the hospital and a presentation at the CME. The ultimate aim was to determine if a cross-cultural teaching program was necessary, and a program would be devised should the study provide evidence of such a need.

3.14 SUMMARY

In this chapter the research design, research methods, and the required population chosen for the study was discussed. The data collection method and analysis were explained with emphasis placed on the ethical considerations. In chapter 4 interpretation of the data and the results of the study are discussed and explained.

CHAPTER 4:
PRESENTATION AND DISCUSSION OF THE RESULTS OF THE RESEARCH

4.1 INTRODUCTION

In this chapter the analysis of the raw data with the aid of STATISTICA Version10 and the results of this analysis, as well as the results of the comparisons between the findings are presented graphically with explanations to understand the relationships or lack thereof.

The data have been presented in four sections as per format of the questionnaire:

Section A Biographical information: Biographical characteristics of the registered nurses were included to understand the effects of gender, age, and nationality variables on the variable of cultural knowledge and sensitivity.

Section B Experiences in diverse cultural settings: Levels of experience with working with other cultures; basic training in nursing other cultures in country of origin; former introductions to and orientation about other cultures in employee hospitals and in the current work environment, and the effect of these variables on the variable of their current cultural knowledge and practice were the information obtained in this part of the questionnaire. This section also asked which cultures they work with and nurse in the current environment.

Section C Cultural Knowledge: Different cultures encountered in the patient and colleague population and their knowledge about these, their opinions of their level of knowledge, as well as stress experienced working with these different cultures were reported on in this section. It was also required of the respondents to report whether they had a support system to deal with stress experienced.

Section D Occurrence reports: Respondents had to indicate how many occurrence reports they completed which resulted from cultural differences.

4.2 SECTION A: DEMOGRAPHIC DATA

This section assessed and compared the age, gender and nationalities of the respondents.

4.2.1 Age

The respondents were classified in terms of the specific age ranges on the questionnaire. Figure 4.1 shows the age distribution of the respondents.

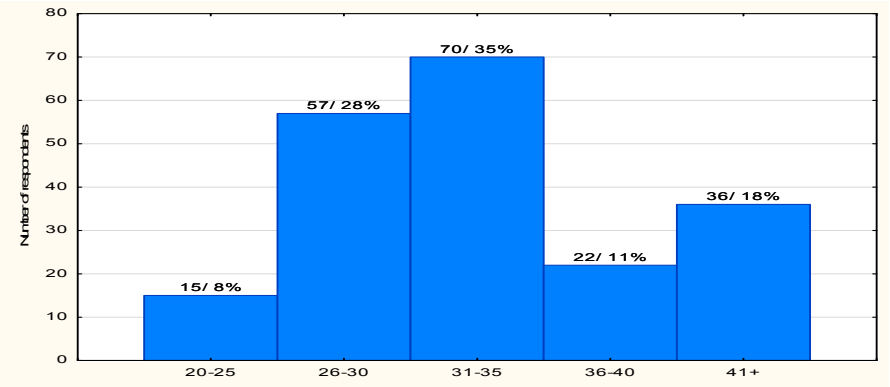

Figure 4.1: Age distribution of respondents

Out of the total number of respondents, 8% (n=15) were between 20 and 25 years old; 28% (n=57) between 26 and 30 years old; 35% (n=70) between 31 and 35 years old; 11% (n=22) between 36-40 years old and 18% (n=36) of the age 41 years and above. The mode is thus 31-35 years of age, with most of the rest of the sample younger than the mode. This shows a young population working in the hospital, as only 29% (n=58) was older than 36 years. This is in contrast to the prediction that the average age of the nurse workforce would be above 50 years of age by 2010 (Stokowski 2008: np).

4.2.2 Gender

There were more females 55% (n=110) than males 45% (n=90) amongst the respondents as Figure 4.2 depicts. The amount of males is a larger proportion than usually present in a female dominated profession. This is normal for this geographical area, as same gender nursing is required from the Muslim religion.

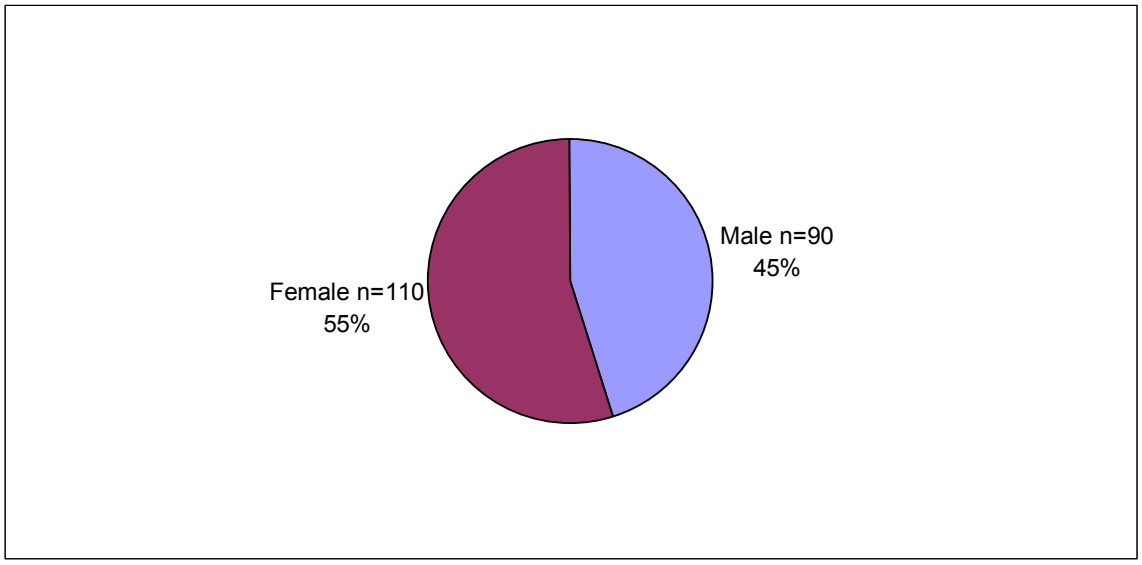

Figure 4.2: Gender Distribution of participants

4.2.3 Nationality

The distributions of the nationalities of the respondents were as follow 5%: (n=10) were Saudi/Palestinian, 31% (n=62), were Jordanian, 12% (n=23) were South African, 17% (n=33) were Lebanese, 20% (n=39) were Indian, 10% (n=19) were Filipino and 7% (n=14) were Malaysian.

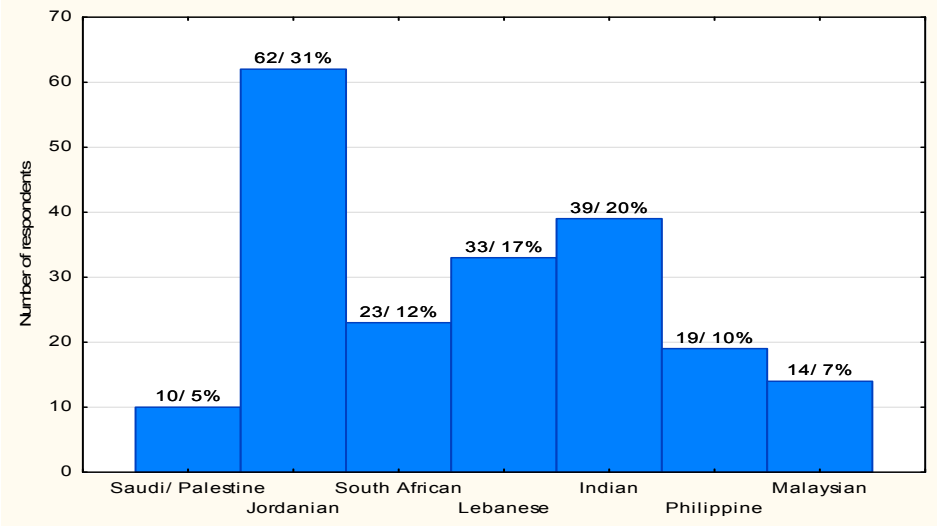

Figure 4.3: Distribution of Nationalities

If the Saudi/Palestinians, Jordanians and Lebanese were counted together, the majority of the nursing staff seems to derive from the Muslim and Gulf countries with a reasonably homogenous culture 53% (n=105). The minorities have a significantly smaller representation

with India being the next largest group 20% (n=39). The Far East is represented by the Filipinos and Malaysians 17% (n=33).The only group representing an area not situated in the Middle or Far East is the South Africans 12% (n=23) which represent a 'Western' and 'African' component. There does not seem to be any other Western cultures represented in the sample e.g. British, American or European citizens.

4.3 SECTION B: EXPERIENCES IN DIVERSE CULTURAL SETTINGS

In this section the respondents were asked if they had any experience in diverse cultural settings, and what amount of years this experience adds up to.

4.3.1 Experience in other hospitals with diverse cultures

The following figure portrays the fact that more than a third of the respondents 39% (n=78) did not have any previous experience with nursing other cultures.

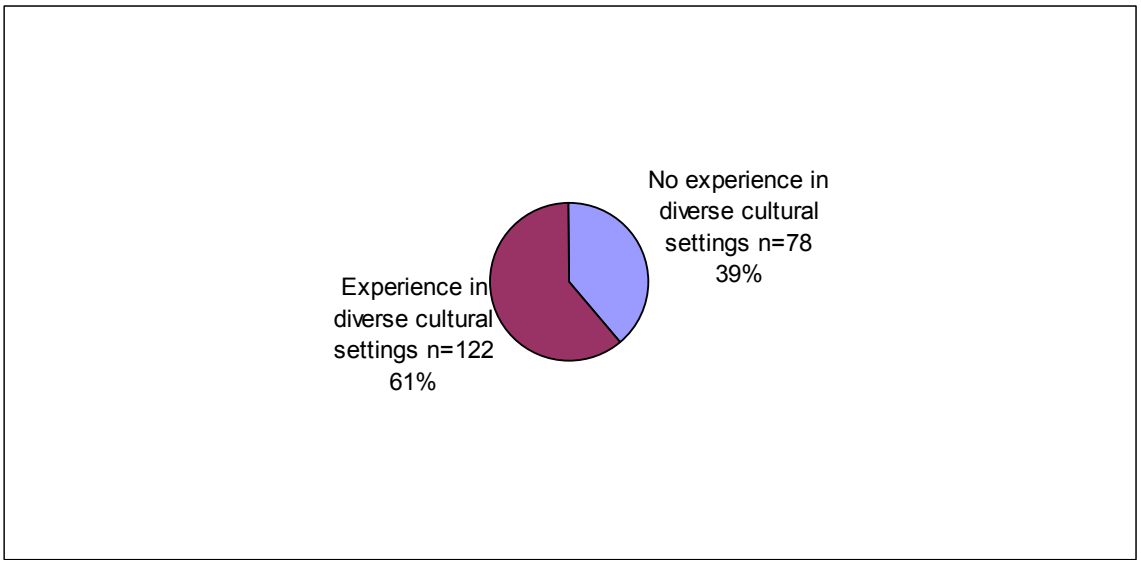

Figure 4.4: Experiences of respondents in diverse cultural settings

Many of their colleagues and patients were the first foreigners they had ever encountered in a professional setting. The other two-thirds 61% (n=122) had experience in diverse cultural settings and nursing other cultures.

4.3.2 Number of years experience with other cultures

The respondents' number of years of experience working with other cultures is indicated by the following figure.

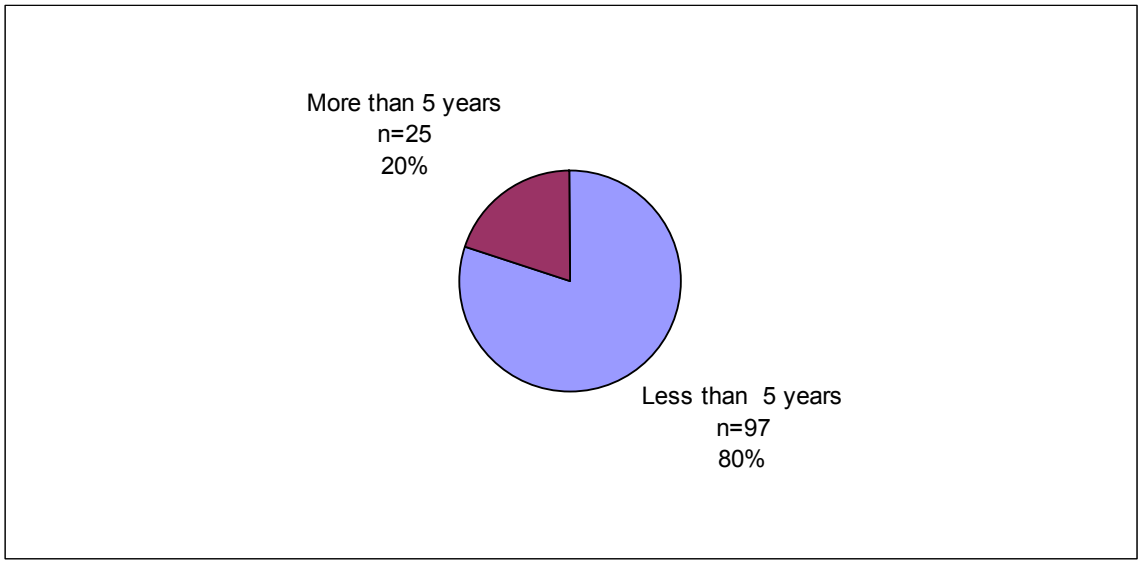

Figure 4.5: Number of years of experience in nursing different cultures

Of the respondents that had previous experience of nursing in diverse cultural settings, 80% (n=97) had less than 5 years of experience and 20% (n=25) had more than 5 years of experience.

With Kruskal-Wallis testing, it was determined that there were significant differences ($p<0.01$) between the nationalities and the years of experiences they have in nursing diverse cultures.

Malaysian, Indian and Lebanese nurses were the respondents that had the **most** experience (between 5-8 years) in diverse cultural nursing. The Saudi/Palestinians, Jordanians and Filipinos averaged 2-5 years experience and South Africans had the **least** experience (only 1 – 2 years) in diverse cultural nursing.

4.3.3 Orientation received in current hospital about other cultures

The majority of respondents indicated that they received orientation regarding cultural diversity in the hospital where the research was done 87% (n=173). There was a small group of 14% (n=27) that did not receive any orientation, possibly indicating a group that was overlooked during orientation or inadequancy in identifying a particular group/individuals for induction as indicated by Figure 4.6.

Chi- square–testing was done to determine whether there was a difference between nationalities regarding orientation received on induction. No such differences was found ($p= 0,64$) so no specific cultural group was excluded from cultural orientation.

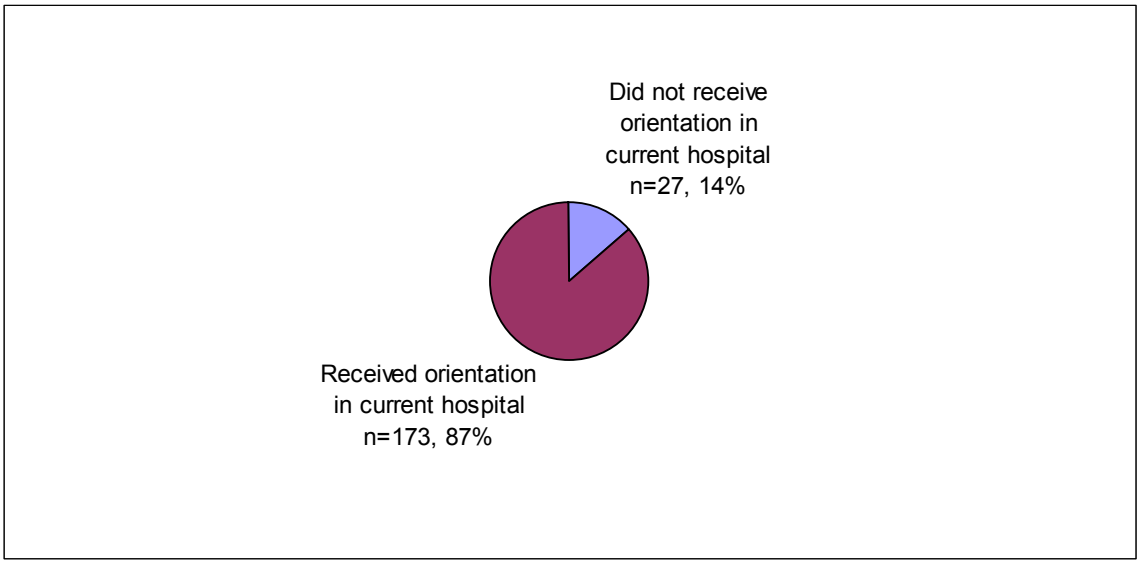

Figure 4.6: Distribution of respondents that received orientation in current hospital about

cultural differences

4.3.4 Orientation received in other hospital about other cultures

Fewer respondents received orientation about cultural diversity in the other hospitals they have worked in than at this specific hospital, as fig 4.7 shows

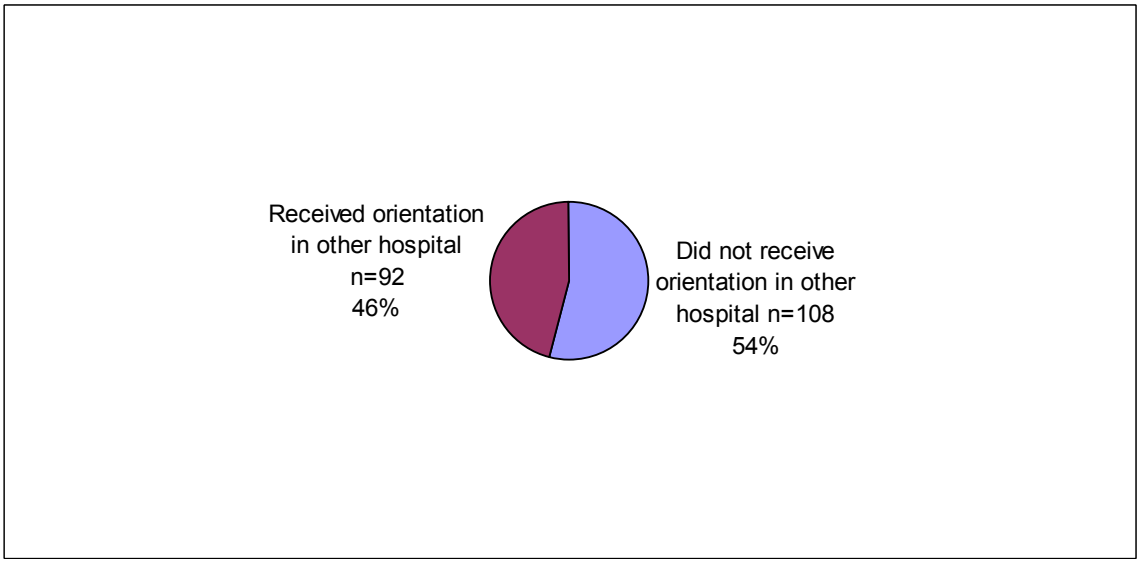

Figure 4.7: Number of respondents that received orientation about cultural diversity in other hospitals

Of those respondents that had experience working with other cultures in other hospitals, 54% (n=108) did not receive any cultural orientation at these hospitals. There does not seem to be a general trend with employee hospitals to orientate people about cultural differences according to the data obtained from this sample. This means that the recruitee hospital would find staff that would only **seem to** have previous experience in cross-cultural nursing care. However, these staff members may **not** necessarily have obtained the skills required to work amongst a multicultural health care team, or nurse multi-cultural patients sensitively. This is reflective of a need for **all** new recruitees to be assessed and taught fundamental cultural aspects, regardless of the level of professional experience.

4.3.5 Training in basic nursing qualification about cultural diversity

Training concerned with cultural diversity during basic nursing courses were received by only 52% (n=104) of the sample, as shown by fig 4.8. This indicates a lack of basic knowledge concerning cultural diversity amongst half of the staff members. These are the same people that work amongst people deriving from vastly diverse cultural backgrounds and that need to deliver culturally sensitive care and work well in a team, without clashes. Thus, not all the developmental institutions in the different countries represented seem to include training that relates to culturally sensitive care in their basic nursing curriculum. This may once again be a problem for the culturally diverse employing hospital which needs to spend more time determining, at the time of induction, which individuals know about such concepts and who needs training.

This might be an important point to consider during the hospital's future recruitment sessions, as it may not want to recruit culturally insensitive people who might be the cause of occurrance reports and need to be trained extensively. Conversely, with such a deficit identified, an appropriate cultural teaching program might address everyone's needs.

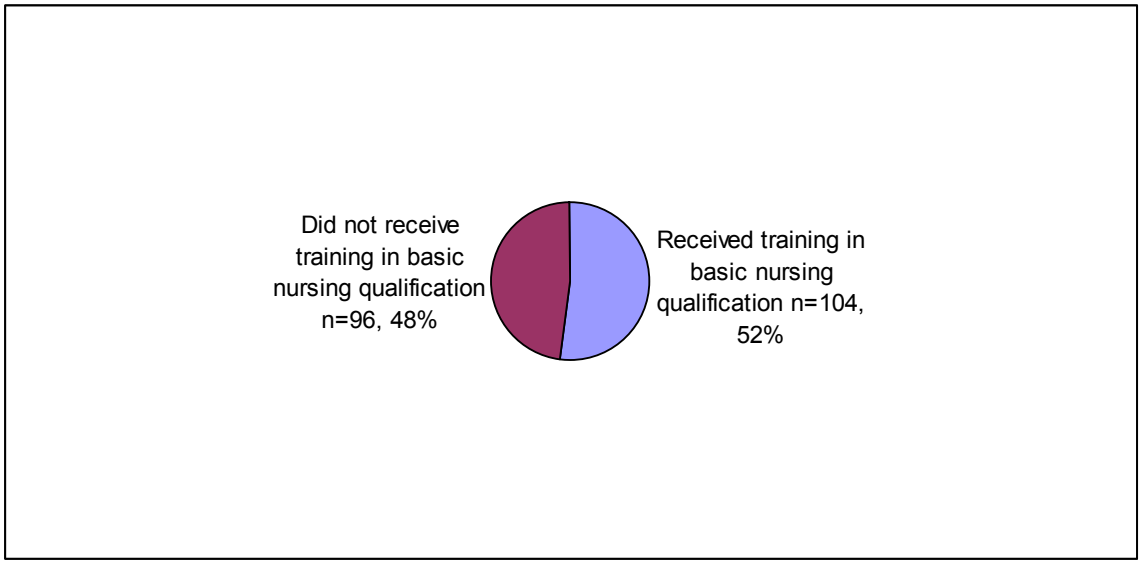

Figure 4.8: Number of participants that received training in basic nursing qualification about cultural diversity

When attempting to determine whether certain nationalities had less basic training in cultural diversity than others, no differences were found (p=0.43). The Filipino's received slightly less training that the other nationalities, reflecting on the fact that the Phillipines is under the top 5 countries exporting nurses due to lack of opportunities for nurses in their country (Walker, 2010:np). The assumption is that they belong to a relatively homogenous culture that does not need extensive input about cultural diversity during training in their own country.

One argument is that the older the person is, the less chance such an individual would have had to receive basic training in cultural diversity, since there was little knowledge about these matters or teaching programs in previous years. However no significant difference (p= 0.17%) were found when age and training in basic nursing education amongst the respondants were compared.

4.3.6 Different cultures of patients

When asked with which nationalities respondents work with on a daily basis, the answers are portrayed in the next figure:

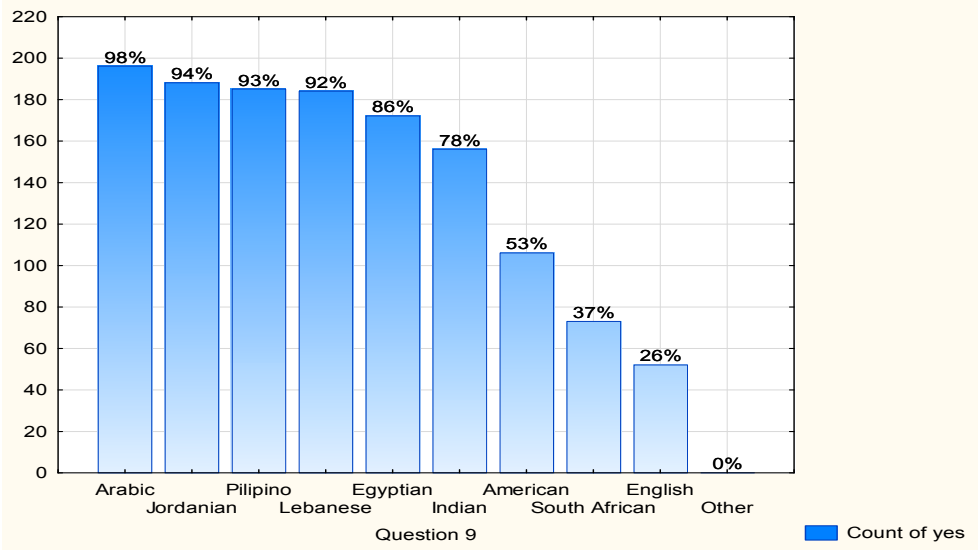

Figure 4.9: Different cultures, respondents work with on a daily basis

Gulf region patients represent the greater majority of the patients encountered on a daily basis. The most significant figures include the following nationalities: Saudis at 98% (n=196), Jordanians 94% (n=188), Filipino's 93% (n=186), Lebanese 92% (n=184) Egyptians 86% (n=172) and Indian patients 78% (n=156).

The numbers for the Filipino patients from the Far East are larger than expected 93% (n=186). This is because of a charity program the hospital runs that include renal transplants and heart surgery, with a large amount of Filipino patients benefiting from such programs. There are smaller components of American 53% (n=106), South African 37% (n=74) and English patients 26% (n=52) encountered on a daily basis.

As a consequence, a program that seeks to place the cultures from the Gulf Region into context should be included, as well as similar programs for the other cultures mentioned – the Filipino, American, English and South African people groups.

4.3.7 Different cultures of colleagues

The majority of respondents worked with Arabic and Filipino colleagues as indicated by the following figure:

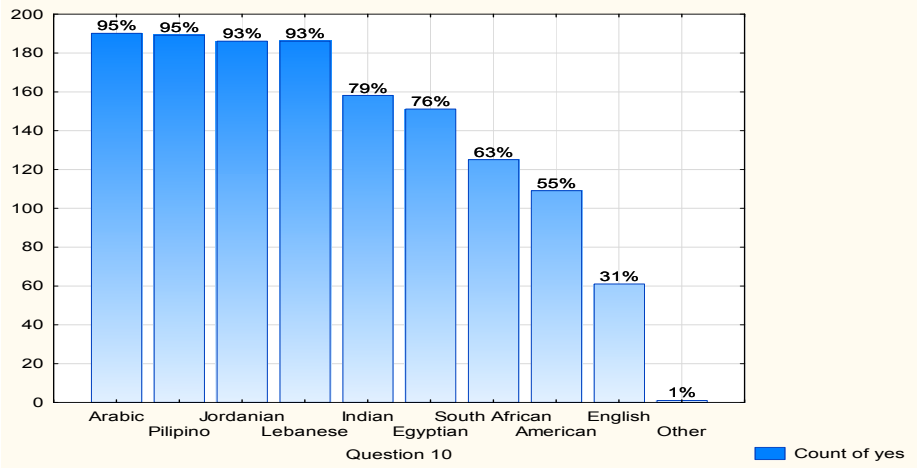

Figure 4.10: The different cultures of colleagues

Lebanese and Jordanian co-workers 93% (n=186) are the second most common groups of nationalities working in the hospital. Some 79% (n=158) of respondents worked with Indians. From the list of respondents, 76% (n=125) worked with Egyptians and 63% (n=126) worked with South African colleagues on a daily basis. There were fewer American 55 %(n=110) and English 31% (n=62) colleagues present in the hospital.

The mentioned information indicates that an exploration of Gulf region cultures should be included in an induction program. However, since all the participants are working with large percentages of people deriving from other cultures (e.g. Filipino, American, English and South African citizens) information about these cultures should also be taught.

4.4 SECTION C: CULTURAL KNOWLEDGE

The respondents' cultural knowledge was measured on a Likert scale where they had to strongly agree, agree, be neutral or disagree with the statements.

4.4.1 The need to know about a patient's culture

In table 4.1 it is shown that the majority 59% (n=118) strongly agreed that there is a need to know more about their patient's culture to be able to meet their needs.

Table 4.1: Cultural knowledge

	Strongly Agree	Agree	Neutral	Disagree
Need to know	117(59%)	81(40%)	1(1%)	0
Has sufficient	43(22%)	63(32%)	78(39%)	16(8%)
Orientation program helps	79(40%)	74(30%)	23(12%)	24(12%)
Has someone to debrief with when clashes related occur	32(69%)	66(33%)	86(43%)	16(8%)

Of the sample 59% (n=118) **strongly agree** and 40% (n=81) **agree** that knowledge about their patients' culture and habits is necessary to meet health care needs. There was an exceptionally small percentage 1% (n=2) that was neutral on this topic. This is a strong indication that the whole population considers cultural knowledge as a necessary tool to be able to function effectively in their environment.

When the answers of the different nationalities were compared, the Chi-square test showed significant differences between the responses (p=0.01). The Saudi/ Palestinians 90% (n=9), Filipino's 84% (n=16) and South Africans 70% (n=14) agreed **strongly** that they needed to know more about the patient's culture to be able to meet their health care needs. The Lebanese, Jordanian and Malaysian groups did not significantly differ in their responses between those that **strongly** agreed and those that just **agreed**.

This indicates that not all the nationalities are equally convinced about their need to know more about another's culture to be able to care for the patient. Thus, suggesting that if some were left without any official form of intervention, they would not initiate inter-cultural dialogue and learning. This puts the emphasis on the need of the employer hospital to diagnose insufficient cultural knowledge and plan on how to address such problems successfully. This is necessary so that the patient would be cared for competently and with adequate cultural sensitivity.

4.4.2 Sufficient knowledge about the patient's culture

Not much confidence was expressed regarding the respondents knowledge of the patients' cultures. Only 22% (n=43) **strongly** agreed that they feel they have sufficient knowledge about their patient's culture while 32% (n=64) **agreed** only. Thus, about half of the sample felt they have sufficient knowledge about their patient's culture, while 39% (n=78) remained

neutral on this question and 8% (n=16) disagreed and thus felt that they do not have sufficient knowledge about their patient's cultures. Consequently, there is significant room for improvement and a definite need can be identified for a program that improves cultural knowledge about patients.

The question above was compared amongst respondents with Kruskal-Wallis testing. Significant differences (p=0.02) were found in the responses of the different nationalities that participated. The Saudi/Palestinian, Jordanian, Lebanese, Indian and Malaysian groups felt less convinced about the issue (only **agree**). The South Africans and the Filipino's mostly answered '**strongly** agreed'.

Nurses from the dominant culture groups represented would not necessarily identify the need to learn more about other cultures. This may be attributed to the fact that they find themselves amongst the majority, and majorities often feel safe in their numbers. Furthermore, they often believe that they are morally right because they all share similar beliefs and cultural practices (Bellevue College 2011:np). The rights of minorities regarding culturally sensitive and competent care need to be highlighted and protected.

4.4.3 Help of an orientation program on Islamic culture at the current hospital to deal with stress

The respondents were asked whether their induction program at the current hospital helped them to deal with stress when working with diverse cultures.

The majority (40%) of the respondents (n=79) strongly agreed with this statement while only 30% (n=74) **agreed**. A further 12% (n=23) of the respondents was neutral on this topic, while 12% (n=24) disagreed and felt the orientation in Islamic culture did not reduce stress levels exacerbated by working with diverse cultures.

This suggests that almost a quarter of all respondents (1:4 nurses) are not convinced that an induction into Islamic culture has helped them to cope in such a multicultural work environment. Emotional stress has a negative impact on the physical performance of nurses and can increase undesirable behaviour like absence from work (Milliken, Clements & Tillman, 2007:203). Negative encounters with a culture alien to one's own, in an environment that is devoid of the emotional and familial structures necessary, can thus contribute to a greater prevalence of occurrence reports.

The answers produced by the different nationalities were compared and a Kruskal - Wallis test determined that there was a significant difference (p=<0.01) between nationalities.

The Saudis, Jordanians, Lebanese, and Malaysians felt **most** strongly about the ability of the Islamic orientation program to alleviate stress, while the South Africans felt **less** strongly. The Indians and Filipino's were the least convinced of the positive effect of such an orientation program on the reduction of their stress levels.

This suggests that there might be a need for a longer and more extensive orientation program in Islamic culture. This may be attributed to the notion that the last mentioned groups are probably less informed about Islam, being from other than Far East/Eastern region religious/cultural orientations.

4.4.4 Presence of a person to debrief with after incident due to cultural diversity

Some 16% of respondents (n=32) **strongly** agreed about having a person to debrief with after events that triggered cultural differences. A further 33% (n=66) of the respondents **agreed** that they had someone to debrief with afterwards. A large amount (n=86) was neutral (43%). A total of 8% (n=16) of the respondents disagreed, and thus had nobody to debrief with after an incident.

This indicates that more than half struggle to deal with events after cultural clashes occur. Since these nurses are working in a foreign country, mostly without their families to support them, the competitive, highly technical and fast-changing working environment (Millikin, Clements & Tillman, 2007:203) can be quite daunting if they do not have a confidante to debrief with when they are lacking in confidence and feeling stressed after a negative occurrence due to cultural diversity. Nursing is already a stressful profession, and when the lack of support in a foreign country is added, one has a recipe for serious emotional, psychological and physical problems in the nursing fraternity of a hospital.

There were no significant differences (p= 0.09) between the different nationalities and their opinions regarding support for debriefing when a stressful incident occurred after dealing with cultural diverse patient/colleague. This means that it is equally stressful for all the nationalities represented when a cultural clash happens, even for those with family support in Saudi Arabia.

4.4.5 Understanding of the different cultures

When asked whether they understood the different cultural needs and taboos of specific population group they care for, the respondents answered as follows:

Table 4.2: Understanding different cultural needs/ taboos of patients from nationalities being nursed

	Strongly agree	Agree	Neutral	Disagree
	1	2	3	4
Arabic	65:33 %	41:21%	74:37%	20:10%
Jordanian	77:39 %	62:31%	42:21%	20:10%
Egyptian	29:14 %	108:54%	59:30%	4:2%
Filipino	26:13 %	108:54%	57:28%	9:5%
Indian	41:21 %	52:26%	80:40%	27:14%
American	9:5 %	97:49%	79:40%	16:8%
South African	23:12 %	81:41%	83:42%	13:7%
English	15:8 %	89:45%	82:41%	14:7%
Lebanese	77:39 %	52:26%	56:28%	12:6%

4.4.5.1 Understanding the Arabic culture

If the patients were Arabic, 33% (n=65) of the respondents **strongly** agreed, 21% (n=41) **agreed** and 37% (n=74) of the participants were **neutral** on the question. A total of 10% (n=20) disagreed that they understand the cultural needs and taboos of the Arabic patient.

This is a large number of respondents 47% (n=94) working amongst an Arabic population that does not adequately understand their patient's needs.

4.4.5.2 Understanding the Jordanian culture

If the patient was Jordanian, 39% (n=77) **strongly** agreed that they understood the culture, while only 31% (n=62) **agreed**, while 21% (n=42) were neutral and 10% (n=20) did not understand the cultural needs / taboos of the Jordanian patient.

4.4.5.3 Understanding the Egyptian culture

If the patient was an Egyptian, only 14% (n=29) **strongly** agreed that they understood their culture, 54% (n=108) **agreed,** while 30% (n=59) were **neutral**. A further 2% (n=4) did not understand the cultural needs/taboos of the Egyptian patient.

4.4.5.4 Understanding the Filipino culture

If the patient was Filipino, only 13% (n=26) **strongly** agreed that they understood their culture, 54% (n=108) **agreed** and 28% (n=57) was **neutral**, whereas 5% (n=9) disagreed

that they understand the culture. As the hospital has a special program dealing with these patients, it is of concern that a third of the sample do not feel confident dealing with this culture.

4.4.5.5 Understanding the Indian culture

If the patient was Indian only 21% (n=41) **strongly** agreed that they understood their cultural needs and the taboos, 26% (n=52) **agreed**, 40% (n=80) chose **neutral**, and 14% (n=27) did not understand the cultural needs/taboos of such patients.

Once again, like with the Arabic patients, there are too large a number of respondents (54%) that did not properly understand their Indian patients.

4.4.5.6 Understanding the American culture

If the patient was American, only 5% (n=9) **strongly** agreed and 49% (n=97) **agreed** that they understood the American's cultural needs and taboos. A total of 40% (n=79) were neutral and 8% (n=16) claimed not to understand the needs/taboos of such patients.

American patients are thus not well understood either as the 48% (n=94) shows that said neutral and disagree. This is understandable as the number of such patients reported being nursed on a daily basis are less than the above Gulf country category of patient.

4.4.5.7 Understanding the South African culture

If the patient was South African then only 12% (n=23) **strongly** agreed that they understood the culture and the taboos. A further 41% (n=81) **agreed**, while 42% (n=83) felt **neutral** about the phenomenon under study, and 7% (n=13) did not understand the needs/taboos of South African patients.

This is also a large percentage 49% (n=98) of patients which is not being understood by their healthcare workers.

4.4.5.8 Understanding the English culture

The English patients were **strongly** understood by only8% (n=15) of the respondents and a further 45% (n=89) **agreed** that they understood the cultural needs and the taboos of such patients. In total 41% (n=82) chose neutral on the questionnaire, and 7% (n=14) did not understand the cultural needs/taboos of an English patient.

A large number of English patients are not understood either 48% (n=96).

4.4.5.9 Understanding the Lebanese

In the case of the cultural needs and taboos of Lebanese patients, 39% (n=77) **strongly** agreed whilst 26% (n=52) only **agreed**. Furthermore, 28% (n=56) of respondents chose **neutral** and 6% (n=12) did not understand the cultural needs/taboos of Lebanese patients.

4.4.5.10 Comparisons between nationalities and gender lines

The combined answers in the neutral and disagree boxes (results ranging from 30-54%) indicate that there is a desire amongst the respondent of all the nationalities to have a better understanding of the cultures that they are nursing. This is remarkable especially when one takes into consideration that most (97%:194) had been through the Islamic cultural orientation and induction. There is also a further need for nurses to understand the cultural expectations and practices of their colleagues and people that they have contact with in their daily professional settings. The majority of the nurses participated in the Islamic orientation program, yet 31- 47% still lack the confidence needed to deal with patients and colleagues from such a background.

This suggests a need for a longer orientation program or more relevant application of the cultural theory learned. The need for knowledge relating to Indian cultural practices and beliefs is also important, since a substantial portion of this population group work in the Gulf region (Pakkiasamy, 2004:np). Although they have traditionally been considered as falling into the working class (Pakkiasamy, 2004:np) their identity as patients and professionals need to be recognised and addressed. Such recognition would possibly cultivate a form of cultural sensitivity amongst Indian nurses that could permeate through their work. This would enable them to recognize the need for cultural sensitivity when seeing to patients and help them to address such a need, improving satisfaction amongst patients and fellow team members.

There is a significant difference in their understanding of Lebanese, Arabic and, Egyptian cultural needs and taboos ($p<0.01$) amongst the gender lines of the respondents. More males than females **strongly** agreed that they understood these cultures. This could be because there was a large component of male Arabic, Jordanian and Lebanese nurses that understood their shared cultures. This component was mixed with female nurses from India and South Africa that felt less certain about this aspect because they only **agree** vs. **strongly** agreed.

This trend is reversed when more females than males ($p < 0.01$) state that they **strongly** agree (versus **agree** only) that they understood Indian cultural needs and taboos. The trend is explained by the fact that most of the workforce was female Indians.

Both genders felt equally strong and **agreed** instead of **strongly** agree that they know about Filipino, American, South African, and English cultural needs and taboos. There is thus room for improvement so that they will eventually feel confident and answer **strongly agree** especially when working with South African patients. This indicates that mostly Middle Eastern male respondents are not as confident as the females, (consisting of a large number of South African female respondents) about South African cultural needs and taboos. This is quite understandable under the circumstances.

4.5 SECTION D: OCCURRENCE REPORTS

In this section respondents were asked to inform the researcher about the number of reports they have to fill in due to incidents attributed to cultural misunderstandings with patients and colleagues.

4.5.1 Occurrence reports filled in due to cultural differences

A total of 60% (n=120) of the respondents reported that they have had to fill in occurrence reports due to cultural diversity.

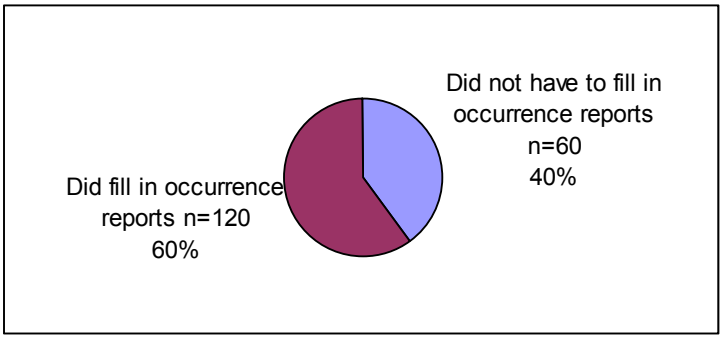

Figure 4.11: Amount of participants that filled in occurrence reports due to incidents with patients/colleagues due to cultural diversity

This reflects that there were a large number of incidents occurring due to cultural misunderstandings and an inability to handle such diversity constructively and wisely. This will eventually negatively influence the hospital's reputation and income as patients would feel dissatisfied when staff is unable to render culturally sensitive care. Staff turnover would also be fast due to clashes with dissatisfied clients (colleagues and patients) and this would cause the need for continuously having to recruit of new staff.

In 'Western' countries there is a move towards the examination of the system's failure and faults instead of focusing on individual mistakes (Williamson, 2010:np). By implementing a program that teaches cultural sensitivity, the hospital would substantially contribute towards addressing systemic problems. This could possibly contribute towards happier patients, a decrease in the turnover of staff, and the retention of content and able staff members. This will in turn help to downsize the expensive recruitment process.

4.5.2 Number of occurrence reports filled in on a monthly basis

Of the respondents 59% (n=119) filled in a report at least once a month, whereas the rest 41% (n=81) reported that they did not fill in any. Of the 59% (n=119), some 6% (n=11) filled in 3-4 Occurrence Variance Reports on a monthly basis relating to cultural diversity problems.

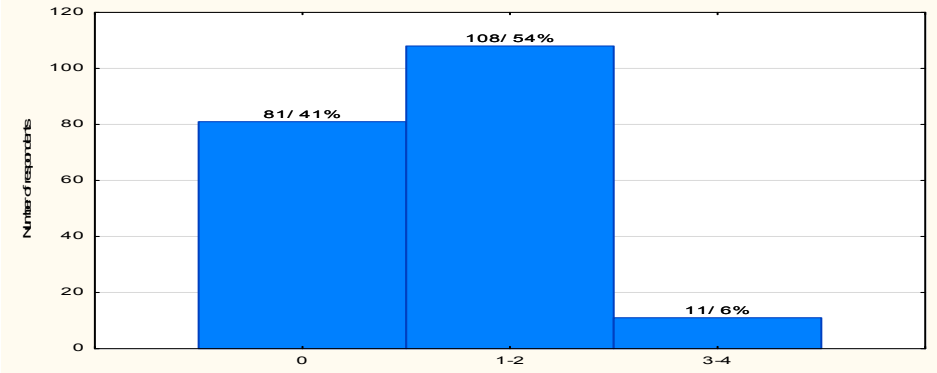

Figure 4.12: Number of occurrence reports filled in on a monthly basis

4.5.3 Relationship of number of OVR's with other variables

When the variables were compared, there were no significant differences between the various nationalities in the number of occurrence reports submitted. There were also no significant differences between those that either did or did not have an orientation program in Islamic culture and the number of occurrence reports that they wrote. The respondent's age or gender also did not impact on the number of occurrence reports that were written.

Those respondents that felt that they should know more about their patient's culture did not write more incident reports. Those that did not have basic training in cultural diversity did not write more occurrence reports; neither did those who had less experience and orientation in another or this specific hospital with diverse cultures.

These reports take time to fill in and to investigate. Furthermore, such incidents cause the patient, staff and colleagues a fair amount of emotional stress, leading to physical

manifestations like hypertension, stomach ulcers and absenteeism (Jennings, 2008:np). Many staff members also tend not to return to complete their contracts after absences for annual leave periods to their home country (Amora, 2012: np). Recruitment and orientation of new staff members are exceptionally expensive and this places a large financial burden on the Hospital. The patient's experiences of such incidents result in an eventual lack of trust in the hospital. Thus, the hospital suffers from a decrease in income due to a preference for other service providers. The financial implications of such a lack of cultural knowledge and sensitive care could be devastating.

4.6 CONCLUSION

In this chapter the responses of the respondents were analysed and compared to determine the status of respondents' knowledge, skills and experience with other cultures. Variables like age, gender, experience, and education were compared amongst nationalities. Additionally, descriptive and inferential methods were used to determine relationships. The results were graphically displayed in figures and tables.

In Chapter 5 conclusions are drawn and limitations of the study are discussed. Recommendations are also made for the application of the results of the study.

CHAPTER 5:
CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In the previous chapter data obtained from the respondents was analysed and presented graphically, as well as interpreted. In this chapter the research findings are summarized, the research limitations explained, conclusions are drawn and recommendations are made.

The overall goal of the research was to determine if there was a perceived need among registered nurses from diverse cultures for a teaching program on cultural sensitivity.

This was done by doing a survey via a data collection form. The purpose of this questionnaire was to determine the different cultures of patients and the nurses in the hospital; the knowledge nurses had about their patients and their colleagues' cultures through previous basic training; previous and current orientation and induction; as well as their experience with working with other cultures. The occurrence of OVR's and the nurses' understanding of the relationship between a lack of cultural knowledge and the prevalence of OVR's were also determined in this study.

5.2 CONCLUSIONS FROM THE RESEARCH

A research population (N=1272) of registered nurses, employed at the time by the private hospital in Saudi Arabia, were considered for the study. From this group 15.8% (n=200) randomly selected respondents' responses were obtained by means of a structured questionnaire.

Data was analysed and calculations were made to determine the relationship between variables with inferential statistics. Results were then displayed through figures and tables.

5.2.1 Status of cultural competence in hospital:

Campinha–Bacote's and Munoz's model (2001:48-52), with its five components of culturally competent care, is used to explain the findings of the study.

5.2.1.1 Cultural awareness

The cultural awareness of the respondents was first measured by determining their biographical, demographic and cultural backgrounds and then comparing their background regarding basic training in cultural nursing. The sample population was young, mostly

younger than 40 years of age. Slightly more than half were females and the females mostly originated from India, South Africa and Malaysia. The unusually large male component came from Jordan and the Philippines. Amongst the Filipino group there was slightly less basic training in cultural nursing care when compared with other cultures.

A lack of knowledge concerning cultural diversity, at the start of their nursing career, was noted amongst almost half of the RN's. Consequently, this lack was also reflected amongst the younger population of this hospital. Learning thus takes place through trial and error and incidents between patients and nurses (and between nurses) occur often, to the detriment of the hospital. These incidents result in OVR's, staff unhappiness and a staff turnover which comes at a great cost to the hospital since it loses experienced staff members and is forced to invest more in training.

The younger nursing corpse, fewer homogeneous cultures amongst the nursing team (ranging from the Far East to Africa), an unusually large proportion of male nurses (more confident and thus less inclined to feel they need cultural education) could be seen as factors that contribute to a lack of cultural awareness among nurses in the specific hospital.

Trends indicating a lack of cultural awareness amongst certain populations, especially the majority homogenous groups, can also alienate the minority heterogeneous cultures as members of the health care team. This needs to be recognized and addressed by employer groups, as ultimately they impact on quality and culturally sensitive patient care.

5.2.1.2 Cultural knowledge

The cultural knowledge of the RN's about nursing in cultural diverse settings was determined by looking at the previous training they had at other institutions and in the current hospital. It was found that generally nurses do not have orientation programs concerned with cultural diversity in other hospitals. Thus, the Saudi hospital actually excelled with their orientation program, and they managed to provide the bulk of their new recruits with a basic orientation program in Islamic culture. One does however need to address the length and quality of this current program being presented, to maximise the experience for all the different nationalities, especially the 'Western' component, about Islamic culture. A few nurses somehow missed the cultural training sessions about Arabic customs and expectations during their induction period. Measures need to be taken to include such overlooked groups during training, since such groups could potentially be the generators of OVR.

Only 1:5 of the RN's are of the opinion that they have enough cultural knowledge about their patients and colleagues. The Saudi/Palestinian, Jordanian, Lebanese, Indian and Malaysian groups are less convinced about the amount of knowledge they have concerning the cultural needs of the diverse cultures they meet. At this level of Campinha-Bacota's and Munoz's (2001: 48-52) model it seems that a lack of knowledge exists in the RN population at the Saudi hospital.

5.2.1.3 Cultural skills

Cultural skills are reflected in this study by the self- reporting of knowledge of different cultures of patients and colleagues the studied population works with. Reported experience in working with other cultures also indicates cultural skills gained during their nursing career.

About 40% of the RN's had no previous experience with nursing individuals from another culture. This indicates a lack of experience in cultural nursing, and thus a lack of cultural skills obtained. The South Africans had the least years of experience, while the Saudi/Palestinians, Jordanians and Filipino's had slightly more. The Malaysians, Indians and Lebanese had the most experience and possibly more cultural skills in dealing with diverse cultures.

A fast turnover of staff members, indicated by the large percentage of staff that has been at hospital for a shorter time period, also has implications for more fast-tracked training in cultural skills so as to be able to render immediate safe cultural competent care.

There were little understanding of the different cultural needs/taboos of Egyptian, Indian, and South African patients, and even less of the American and the English patients.

Jordanian and Arabic patients were the best understood. Nevertheless, at least a third of the RN's do not even understand enough of this latter group of patients that they encounter more often. This reflects in the OVR's received. As many as 60% of the RN's had to fill in such reports. This reflects that a large amount of the incidences are occurring because of a lack of an active effort to seek cultural skills. When individuals are fully convinced that they are dealing with issues (according to their culture) in a correct manner they will not give way, compromise or negotiate during an arguments with patients or colleagues. Having the necessary cultural skills will encourage nurses to listen to other people and try to accommodate individual and cultural needs, resulting in fewer OVR's and happier patients and colleagues.

Skills are also reflected by the nurses' confidence about knowledge relating to the patient's culture. Only 54% agreed that they had sufficient knowledge about the patient's cultural practices, beliefs, and expectations. The rest did not have the confidence to report affirmatively in this aspect of nursing. About 1:4 RN's do not believe that their induction adequately helped them to deal with cultural diversity in their current setup. Such a lack of cultural skills are reflected in the lack of confidence and in stress experienced. Emotional stress becomes evident and inhibits nurses to function effectively, which leads to an increased absence from work, especially after negative cultural encounters. A need for a more extensive Islamic orientation program and care, as well as a program covering the needs of the variety of cultures nurse's encounter daily, has been identified with the analysis of the data presented in this study.

5.2.1.4 Cultural Encounters

Reported knowledge of different cultures, the need to debrief, and stress reported after a negative encounter reflect the results of cultural encounters and determine whether a nurse will actively seek such encounters. Nurses involuntarily encounter the following patients on a daily basis: an Arabic majority (Saudi's, Jordanians, Lebanese, Egyptian), but also a large amount of Filipino's due to a renal transplant and heart surgery charity outreach program. American, South African and English patients are also nursed on a daily basis. This means that knowledge covering a large cultural spectrum is needed. Direct interaction with culturally diverse patients on a daily basis increases cultural competency (Flowers 2004:50).

Furthermore, over a third of the RN's work with English colleagues on a daily basis, half of them work with Americans, almost two-thirds with South Africans and 76% works with Indian colleagues. The largest colleague group encountered by all the nurses (80% and above) are Arabic, with the Filipinos closely following.

Thus Gulf Region cultures should also be explored in cultural orientation programs, as well as all of the cultures mentioned (Far Eastern, American, English, and African).

Flowers (2004:51) also mention that since the 1970's the trend has been for foreigners working in a country to maintain their unique cultural practices and traditions instead of assimilating with the majority culture. This means that instead of trying to blend and seek cultural encounters, people tend to stay together in familiar (and 'safe') circles. Thus they do not mix and adapt the new culture unless it is enforced. This needs to be addressed among nurses to encourage cultural encounters, for their patient's sake as well as for the improvement of team relationships.

Cultural encounters are enforced on a daily basis. Negative incidents can often induce unnecessary stress, especially if the person involved cannot debrief with anyone they can trust. This stress is emotionally debilitating regardless of nationality. While a cultural encounter in this context is rather enforced than being sought, it has the effect of hastening this process of learning from other cultures. Employing hospitals would want to proactively facilitate the process of fast-track learning about other cultures. This would be followed up with a more comprehensive program instead of addressing it retrospectively with OVR's.

5.2.1.5 Cultural desire

This is the motivation to become culturally aware and to seek cultural encounters on one's own accord. This is also the willingness to be open to others, accept and respect cultural differences, and to be willing to learn from others (Flowers, 2004:50). Most of the RN's strongly agreed that knowledge about their patient's culture and habits is necessary to meet their health care needs. There were significant differences between the nationalities who were not equally convinced about the necessity to know more about other cultures. The employing hospital is ultimately the responsible party in this scenario and should initiate the necessary programs and address the cultural needs of their paying patients in this manner.

The ultimate goal and rationale for cultural sensitive care is for the nurse/employing hospital to give their patients a voice and to be advocates for this inclusive form of care.

By ensuring that a program exists to help create a desire amongst staff to know more about other cultures, they will help staff to also enable patients to have a voice in their total care.

5.3 LIMITATIONS

A few matters that burdened the process of the study follow:

5.3.1 Obtaining approval and issues with privacy

Obtaining approval from the hospital to conduct the study had to be extensively negotiated with constant clarification. After a long delay the approval was given for the study on the condition that the name of the hospital was not to be mentioned in this thesis. Because of the need of privacy and confidentiality expressed by the hospital, the amount of OVR's actually generated could not be obtained which would have reflected a more objective number instead of using the respondents' subjective report.

5.3.2 Cultural and religious issues

A few nurses refused to complete the questionnaire because of cultural and religious issues from their side, but after the field workers explained the benefits of the study and the anonymity that was guaranteed, they were willing to complete the questionnaires.

5.3.3 Language

Questionnaires were set in English; the Arabic speaking respondents felt that if the questions were also in Arabic it would have been easier for them to complete.

5.3.4 Inability to generalise

Only the one hospital in Saudi Arabia was part of the study, thus the results cannot be generalized to include other hospitals in this region.

5.3.5 Time constraints and responses

The nurses were extremely busy in their units and this delayed the completion of some of the questionnaires. After a reminder was e-mailed to all the selected respondents, the problem was solved.

5.3.6 Sample size

Some questionnaires (27) were incomplete and had to be discarded, thus slightly decreasing the sample from 18% to 15.8% of the population.

5.3.7 Reliability of the instrument

The options of one of the questions in the instrument (years of experience with nursing diverse cultures) were not mutually exclusive, and this resulted in having to portray this data in a less refined way than desired.

5.4 RECOMMENDATIONS

The following is recommended on the basis of the findings in this study:

5.4.1 Programs for new recruits and refresher courses for other staff

A long term culturally sensitive educational program for the new RN recruits and other health care providers should be initiated, and mandatory refresher courses for the staff that has been employed for a long period of time at the hospital should be implemented.

5.4.2 Evaluation of success of programs

This program should be evaluated at multiple levels, including cultural knowledge, cultural awareness and cultural skill levels assessment also using Campinha-Bacota and Munoz's evaluation instrument.

5.4.3 Integration into basic programs

The nursing college at the hospital where the study was conducted should implement a required integrated cultural sensitivity component into its training program to ensure that professional development in this area occurs.

5.4.4 Support during stressful situations

Stress debriefing programs, aimed to assist the registered nurse with handling cultural stress- induced problems, should be offered with a follow-up to evaluate the outcome of the debriefing session.

5.4.5 Quality improvement programs

Quality improvement programs that include culturally and linguistically appropriate patient survey methods and the development of process and outcome measures, reflecting the needs of the minorities and the multicultural population, should be initiated.

5.4.6 Recruitment

The hospital should include multicultural managers in their recruitment team, reflecting the diversity of the staff and the patients, to address diversity needs throughout the hospital.

With the recruiting of new staff members, potential employees should be questioned about their former work experience with diverse cultural patients and colleagues. This experience will benefit the hospital and could minimize the occurrence reports caused by cultural difference.

5.4.7 Establishment of committee

Establishing a Cultural Diversity committee to represent and help guide delivery of culturally sensitive care would benefit the hospital. Such a committee would include administrators and a multi disciplinary group of health care providers like doctors, assistants, social workers and registered nurses as well as a community member.

5.4.8 Regular seminars and workshops to align with international trends

Regular seminars and workshops presented by experts in the field regarding the understanding and rendering of optimal health care to the patients from diverse cultures would be highly beneficial to the staff and expose them to frontline advances internationally on cultural sensitive care.

5.5 CONCLUSION

The aim of the study was to explore the need for a teaching program on cultural sensitivity in the private hospital in Saud Arabia. It was hypothesized that:

- diverse bio-and demographical/culture/education backgrounds of the nursing staff would input on their cultural knowledge and sensitivity of care given, and that
- the amount of occurrence reports that were generated due to cultural differences and clashes indicate a need for a teaching program on cultural sensitivity.

This study reflects a youthful component of nurses from very diverse cultures working in the hospital, with a very large variety of patients of equally diverse cultures. A large amount of male nurses is present in the usually female dominated profession, as is normal for this geographical area.

Little orientation was given in basic programs of nursing over the whole spectrum of nationalities, but even less was reported amongst the Filipino group

Almost half of the respondents lack previous experience with nursing other cultures, (possibly because of the age of the sample), especially amongst the South Africans, Saudi-Palestinians, Jordanians and the Filipino's. About half of the staff felt they had insufficient knowledge about their patients' culture, especially the Saudi-Palestinians, the Jordanian, Lebanese, Indian and Malaysian contingent.

The majority of respondents filled in an OVR relating to cultural diversity problems on a monthly basis, while some had to do this more regularly. This reflects a large number of incidents due to cultural misunderstanding and inability to handle cultural diversity constructively and wisely.

A more extensive training program in culturally sensitive care for the nursing staff needs to be developed and implemented. The lack of such training could cost the hospital dearly in the form of revenue lost, due to unhappy patients and large staff turnover resulting from these incidents.

Both of the hypotheses were validated by the study. The bio/demographical/cultural and educational backgrounds of the nurses significantly influence cultural knowledge and experience and indicate a need for more knowledge about cultural diversity to address their patients' cultural healthcare needs. The hospital, nurses and patients would thus greatly benefit from a cultural sensitivity education program.

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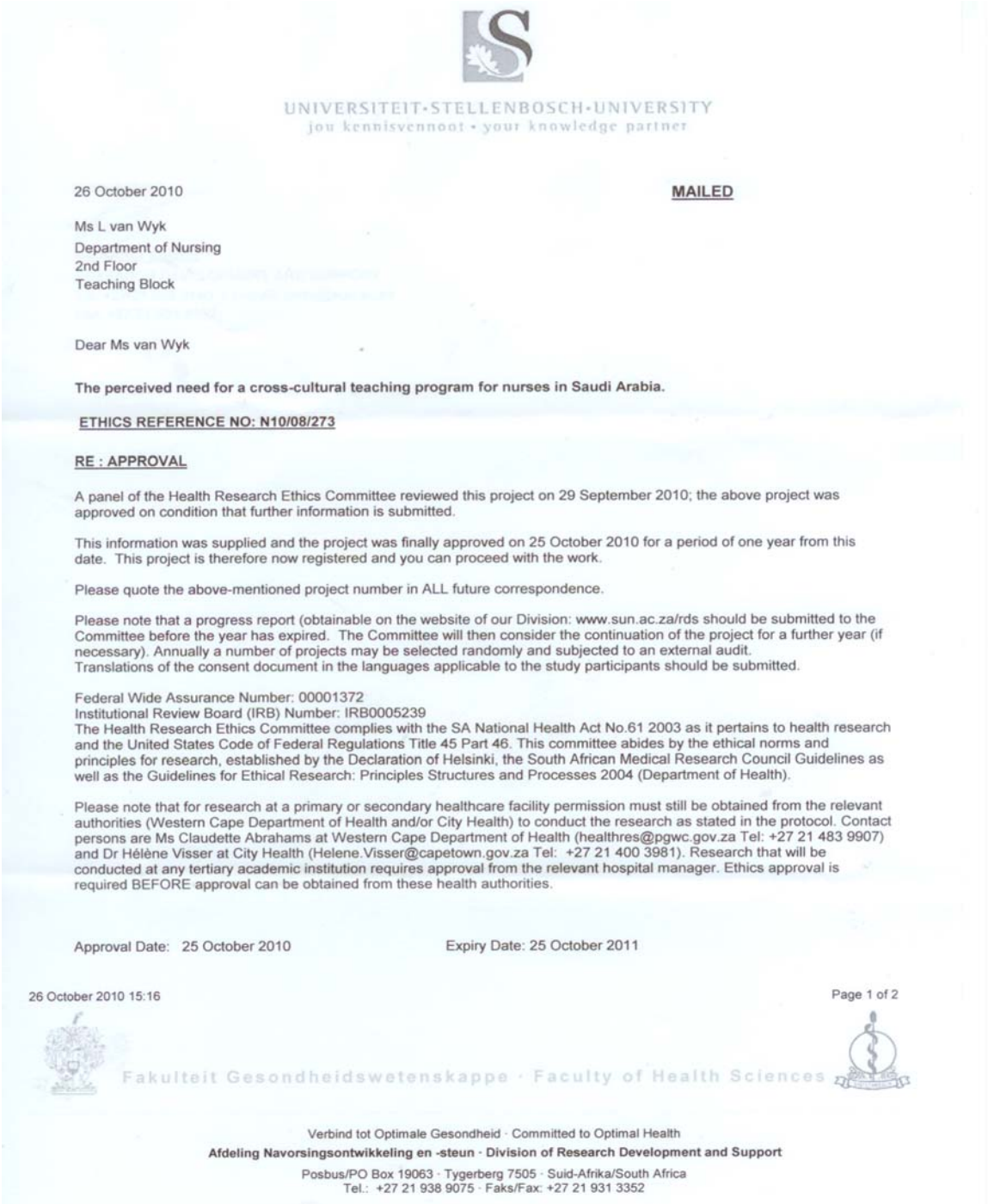
ANNEXURES

ANNEXURE A: ETHICAL CONSENT FROM THE UNIVERSITY OF STELLENBOSCH FOR THE RESEARCH



UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot • your knowledge partner

26 October 2010 **MAILED**

Ms L van Wyk
Department of Nursing
2nd Floor
Teaching Block

Dear Ms van Wyk

The perceived need for a cross-cultural teaching program for nurses in Saudi Arabia.

ETHICS REFERENCE NO: N10/08/273

RE : APPROVAL

A panel of the Health Research Ethics Committee reviewed this project on 29 September 2010; the above project was approved on condition that further information is submitted.

This information was supplied and the project was finally approved on 25 October 2010 for a period of one year from this date. This project is therefore now registered and you can proceed with the work.

Please quote the above-mentioned project number in ALL future correspondence.

Please note that a progress report (obtainable on the website of our Division: www.sun.ac.za/rds should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly and subjected to an external audit.
Translations of the consent document in the languages applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239
The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Hélène Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

Approval Date: 25 October 2010 Expiry Date: 25 October 2011

26 October 2010 15:16 Page 1 of 2

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ANNEXURE B: CONSENT OBTAINED FROM THE HOSPITAL WHERE RESEARCH TOOK PLACE

MEMORANDUM

DATE: 22nd February, 2010 REF: MK-KT-044

TO: Mr. Abdulrahman Al-Dakhayel, Deputy Executive Director, Operations

FROM: Dr. May Al-Khunaizi, Executive Director

SUBJECT: Ms. Leoni VanWyk, Case Manager – EAC & PMRD

Pursuant to your memo regarding the above subject, we have no objection if Ms. VanWyk distributes her survey to nurses to complete, but not during work time.

The study should not refer to our hospital name or any confidential information related to the hospital. Please have Ms. VanWyk remove [redacted] Hospital's name from the questionnaire.

Kind regards

Dr May Al-Khunaizi
Executive Director

The name of the hospital has been removed from the original consent form as per condition for approval to do the study at the hospital.

ANNEXURE C: COVERING LETTER TO THE RESPONDENTS

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT:

EXPLORING THE PERCEIVED NEED AMONG NURSES FROM DIVERSE CULTURES FOR A TEACHING PROGRAM ON CULTURAL SENSITIVITY.

REFERENCE NUMBER: N10/08/273

PRINCIPAL INVESTIGATOR: LEONI VAN WYK

ADDRESS: SAUDI ARABIA

CONTACT NUMBER: +966554516658

You are being invited to take part in a research project Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff or doctor any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is entirely voluntary and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part

This study has been approved by the Committee for Human Research at Stellenbosch University and will be conducted according to the ethical guidelines and principles of the international Declaration-of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

- By this study the researcher is attempting to measure the perceived need for a program teaching cross-cultural practices for nurses in their health care setting. The researcher will also attempt to identify whether the nurses recognise the role cultural differences play in the generation of occurrence report
- This study will be conducted at Private Hospital in Saudi Arabia, amongst the registered nurses working in the hospital. Of the total population of 1270 nurses 250 were randomly chosen by the computer.

- A self administrative questionnaire was designed to be completed by the nurse chosen by the computer.
- The questionnaire will include a series of questions relating to measurable elements based on the Likert scale. This study only requires filling the questionnaire.
- Confidentiality will be maintained by asking the respondent not to identify them self on the questionnaire

Why have you been invited to participate?

- The names of all the registered nurses working in the hospital have been entered into a computer program and the computer randomly selected 250 people to participate in the study.

What will be you responsibilities be?

- Please complete the consent form given to you by the field worker and give back in the envelope supplied. The questionnaire supplied should take you 10-15 minutes to complete. Please place the completed questionnaire in the survey box allocated to the area

Will you benefit from taking part in this research?

- The study is voluntary. There is no direct benefit by way of financial compensation to anyone that participates. There is no negative consequence to individuals that does not want to take part. The information that will be obtained will be used to determine the need for further teaching programs in the form of cultural sensitisation.

Are there in risks involved in your taking part in this research?

- There are no risks Involved In this study Declining to participatewill not affect you negatively In any way. You are free to withdraw from the study at any point, even if you do agree to take part

If you do not agree to take part, what alternatives do you have?

- If you do not wish to take part in the study, you just need to inform the researcher or field worker that you don't want to lake part,

Who will have access to your medical records?

- There is no medical record or any other documentation with your name on except the consent form that you sign, this form will be given to the researcher and it will be filed and locked away.

- Nobody will have any access to your consent form and questionnaire answered, it is thus totally confidential also because the anonymous questionnaire handed in is handed in separately to your consent form.

Will you be paid to take part in this study and are there any costs involved?

- There will no payment for taking part in the study and there will be no cost involved for you.

Is there any thing else that you should know or do?

- You can contact the Health Research Ethics Committee at 002721-9388207 if you have any concerns of complaints that have not been adequately addressed, You will receive a copy of this information and consent from for your own records.

Declaration by participant

By signing below, I…….. agree to take part In a research study entitled EXPLORING THE PRECEIVED NEED AMONG NURSES FROM DIVERSE CULTURES FOR A TEACHING PROGRAM ON CULTURAL SENSITIVITY

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable,
- I have had a chance to ask questions and all my. questions has been adequately answered
- I understand that taking part in this study is voluntary and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way,
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to

Signed at (Place) ....on (date) ……..2010

…….. ……..

Signature of participant **Signature of witness**

Declaration by investigator

I (name) ….Leoni van Wyk …….. declare that I

- I explained the information in this document to ……
- I encouraged him/her to ask questions and took adequate time to answer them
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter (if a interpreter is used then the interpreter must sign the declaration below),

Signed at (place) . .....on (date) . ..... 2010.

Declaration by interpreter

I (name)……. declare that I assisted the investigator …….. to explain the Information in this document to…… using the language medium of English.

- We encouraged him/her to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the participant fully understands the content of this Informed consent document and has had all his/her question satisfactorily answered.

Signed at (place) …… on (date)……..2010

……. …….

Signature of interpreter Signature of witness

ANNEXURE D: QUESTIONNAIRE

Questionnaire:

PERCEPTIONS OF STAFF ABOUT CROSS-CULTURAL PRACTICES IN SAUDI ARABIA.

Student Number: 15658554 **Course: MCUR Leoni van Wyk Nursing Science**

A BIOGRAPHICAL INFORMATION (Please mark with circle that is applicable.)

1. **Age.**

   20-25 = 1

   26-30 = 2

   31-35 = 3

   36-40 = 4

   41-50 = 5

   60-65 = 6

2. **Gender:**

   Male **= 1**

   Female **= 2**

3. **Please state your nationality.**

B. EXPERIENCE IN DIVERSE CULTURAL SETTINGS.

4. **Do you have experience in working in other hospitals which rendered care over a wide spectrum of cultures?**

   Yes = 1

   No = 2

5. **If you have answered Yes to the above, for how long?**

   Less than one year = 1

   1-2 years = 2

   2-3 years = 3

   4-5 years = 4

   5-8 years = 5

   More than 8 years = 6

6. **Have your received orientation in this hospital about cultural diversity?**

   Yes = 1

   No = 2

7. **Have your received orientation in another hospital about cultural diversity?**

   Yes = 1

   No = 2

8. **Have you had training in your basic nurse's qualification about cultural diversity?**

   Yes = 1

   No = 2

10. Mark the different cultures of the patients that you work with on a daily basis.

Arabic	= 1
Jordanian	= 2
Egyptian	= 3
Philippine	= 4
Indian	= 5
American	= 6
South African	= 7
English	= 8
Lebanese	= 9
Other (Please specify)	

10. Mark the different cultures of the colleagues that you work with on a daily basis.

Arabic	= 1
Jordanian	= 2
Egyptian	= 3
Philippine	= 4
Indian	= 5
American	= 6
South African	= 7
English	= 8
Lebanese	= 9
Other (Please specify)	

C. CULTURAL KNOWLEDGE CURRENTLY:
(Please respond to the following statements on a scale of 1 to 4 by placing a tick (√) in the appropriate column or box):

QUESTION	Strongly agree	Agree	Neutral	Disagree
	1	2	3	4
11. Do you need to know about your patient's cultural and habits to meets his/her healthcare needs ?				
12. Do you feel you have sufficient knowledge about your patient's culture in your department?				
13. Has your orientation program about Islamic culture helped you deal with possible stress induced by working with diverse cultures?				
14. Do you have somebody you can debrief with if you had a stressful incident after dealing with a cultural diverse patient/ colleague				
15. Do you understand the different cultural needs and taboos of the patients that you nurse?				
Arabic = 1				
Jordanian = 2				
Egyptian = 3				
Philippine = 4				
Indian = 5				
American = 6				
South African = 7				
English = 8				
Lebanese = 9				
Others (Please state)				

D. OCCURANCE REPORTS

16. **Have you had to fill in any occurrence reports due to incidents with patient/colleagues due to cultural diversity?**

Yes = 1

No = 2

17. **How many occurrence reports do you have to fill due to cultural diversity on a monthly basis?**

None = 0

1-2 = 1

3-4 = 2

5-6 = 3

7-8 = 4

9-10 = 5

ANNEXURE D: DECLARATION OF TECHNICAL FORMATTER

Lize Vorster Communication

To whom it may concern

This letter serves as confirmation that I, Lize Vorster, performed the technical formatting of Leoni van Wyk's thesis. Technical formatting entails complying with the USB technical requirements.

Yours sincerely

Lize Vorster
Language Practitioner

Vygie street 9, Welgevonden Estate, Stellenbosch, 7600 * e-mail: lizevorster@gmail.com * cell: 082 856 8221